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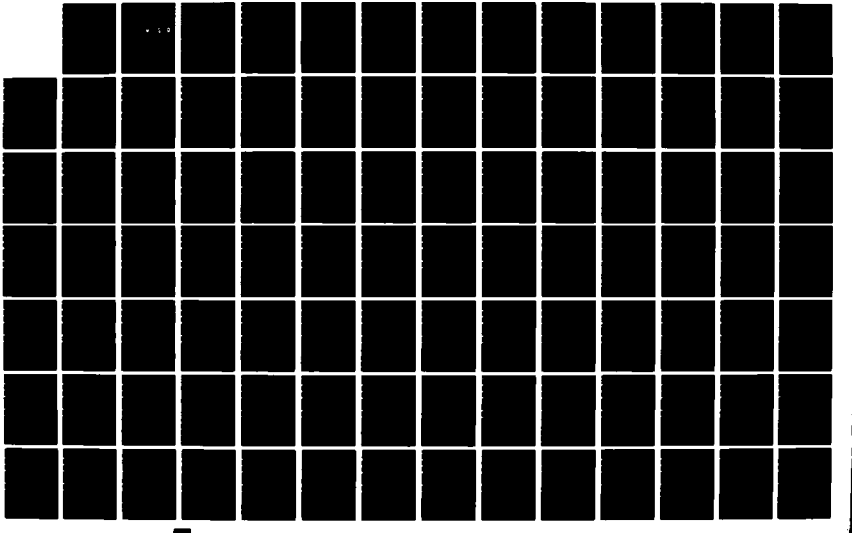

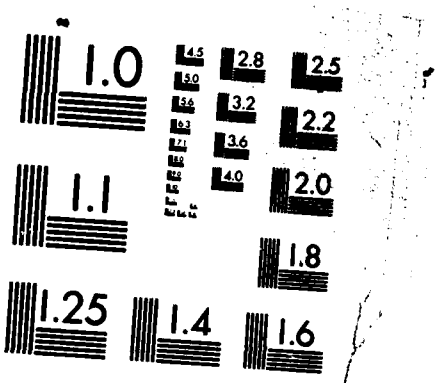

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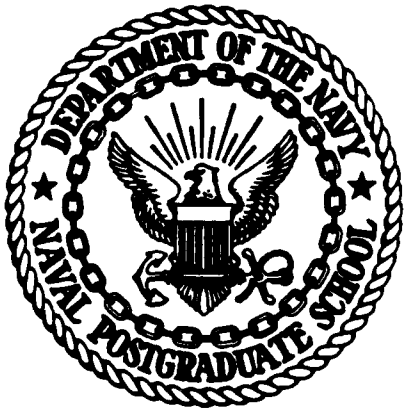

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THESIS

THE PROCESS FOR DETERMINING THE MANPOWER AND BUDGET REQUIREMENTS FOR A NAVAL HOSPITAL

by

Brian George Brannman

and

Pamela Shayne Brannman

December 1985

Thesis Co-Advisors: David Whipple
Shu Liao

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In the span of the past twenty years, significant pressure has been exerted on each of the services, by Congress and senior officials in the Department of Defense, to develop methodologies for providing objective, rigorously derived, quantitative justification for resource requirements. Of the programs that resulted, at the Department of Defense level and within the Navy, several were intended to support the manpower and budget requirements determination process for naval hospitals. Programs eminating from the Department of Defense were the Uniform Chart of Accounts (UCA), Uniform Staffing Methodologies (USM), the Defense Enrollment Eligibility Reporting System (DEERS), and CHAMPUS. Navy sponsored programs were eventually incorporated under the umbrella of the Navy Manpower Engineering Program (NAVMEP). This thesis attempts to describe the process employed within the Navy medical department to determine manpower budget requirements for naval hospitals,

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The Process for Determining the Manpower and Budget Requirements for a Naval Hospital

by

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ABSTRACT

In the span of the past twenty years, significant pressure has been exerted on each of the services by Congress and senior officials in the Department of Defense to develop methodologies for providing objective, rigorously derived, quantitative justification for resource requirements. Of the programs that resulted, at the Department of Defense level and within the Navy, several were intended to support the manpower and budget requirements determination process for naval hospitals. Programs emanating from the Department of Defense were the Uniform Chart of Accounts (UCA), Uniform Staffing Methodologies (USM), the Defense Enrollment Eligibility Reporting System (DEERS), and CHAMPUS. Navy-sponsored programs were eventually incorporated under the umbrella of the Navy Manpower Engineering Program (NAVMEP). This thesis attempts to describe the process employed within the Navy medical department to determine manpower budget requirements for naval hospitals, the role of each echelon of the chain of command, and the contributions of the formal programs to the process.

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I. INTRODUCTION

A. BACKGROUND

Naval hospitals form the cornerstone of the Navy's health care delivery system. Their size and complexity run the gamut from large teaching facilities of 500 or more beds to small overseas hospitals of fifty beds or less. The populations they serve vary from location to location. Some serve active duty Navy and Marine personnel and their families almost exclusively while others may serve a broad mix of active duty, dependents, retirees, and other beneficiaries from all age and socioeconomic groups. The efforts to satisfy the health care needs of each of these diverse beneficiary groups have spawned a network of nearly unique facilities in terms of capabilities, staffing mix, and resource requirements. Efforts to manage this network are complicated by the concurrent requirement that the same resources employed to meet the peacetime health care delivery mission are capable of accomplishing their primary mission of providing wartime or contingency medical support. The challenge facing the leadership of the medical department has been the development and implementation of a process for determining resource requirements for hospitals and other facilities and making allocations of those resources in a manner which will support the two missions.

B. PURPOSE

For the past twenty years an increasing amount of pressure has been exerted on each of the services, by Congress and senior officials within the Department of Defense, to provide systematic, objective, and quantifiable justification for resource requirements identified in the budget process. The result of these efforts has been the development of a variety of formal programs designed to augment the planning process. The purpose of the research for this thesis has been to examine the current process within the Navy medical department for determining manpower and budget requirements for a naval hospital and identifying the extent that formal programs devised within the Navy and the Department of Defense contribute to decision making at each level in the chain of command. The authors also sought to explore some of the reasons why particular programs were or were not used, and the possible direction of future planning efforts.

C. CONTENT

Chapter II is intended to provide the reader with a description of the various formal programs which were designed to support the resource requirements determination process. The chapter begins with an overview of the Navy medical department's mission and organizational structure and a brief summary of the Planning, Programming and Budgeting System to

assist readers unfamiliar with either the Navy or the Department of Defense budget mechanism.

Chapter III is an effort to describe the actual process currently used within the medical department to determine manpower and budget requirements for a naval hospital, emphasizing the role of each echelon in the chain of command and the contribution of the programs discussed in Chapter II. In addition, the chapter attempts to demonstrate how appropriated resources are allocated, again point out the role of formalized programs.

Chapter IV presents the conclusions of the authors, based on their research, and their projections for the direction of the resource requirements determination process and the future role of the formal programs.

D. RESEARCH APPROACH

Research for this thesis was conducted in two phases. First, the authors reviewed available literature and directives concerned with the determination of manpower and budget requirements and the formal programs designed to support that process. The authors then conducted interviews with key personnel within the Office of the Director of Navy Medicine, Naval Medical Command, three Geographical Naval Medical Commands, and two naval hospitals to gain an understanding of how resource requirements were actually identified, programmed, and allocated.

Hospitals are complex entities performing a wide range of services through a variety of mechanisms. In naval hospitals this complexity is compounded by the requirement to plan for both a peacetime and a wartime mission in an environment in which the availability of manpower and fiscal resources is subject to constraints imposed by Congress or shifting priorities elsewhere within the Navy. The authors have not written this paper with the objective of providing an all-encompassing description of how naval hospitals are staffed and funded. The scope of such a project exceeds the limitations in time and resources allotted for thesis research and the talents of two graduate students. This paper does present the authors' observations based on the findings of their limited research and it is hoped that this thesis can serve as a stepping stone for others pursuing a more indepth study of the manpower and budget requirements process.

II. THE NAVY MEDICAL DEPARTMENT AND THE INPUTS AVAILABLE FOR DETERMINING RESOURCE REQUIREMENT

This chapter will describe the naval hospital and its role and relationships as a component of the Navy Medical Department. In addition it will identify and describe the various programs which have been developed to provide inputs to the process of determining manpower and budget requirements for naval hospitals.

A. MISSION OF THE NAVY MEDICAL DEPARTMENT

The Secretary of Defense has defined the primary national security objective as the preservation of the United States as a free nation with its fundamental institutions and values intact. [Ref. 1] The Navy's mission supporting this objective is to protect the sea lanes, provide sea control, and project power ashore. The Navy Medical Department contributes to the accomplishment of the Navy's mission by addressing two primary objectives. The first, the readiness mission, is to maintain the health of the active duty force and be prepared to attend the sick and wounded in wartime. The second objective, the peacetime benefit mission, is to provide medical care to eligible military dependents and retirees as resources permit. [Ref. 2:p. 00-1]

B. ORGANIZATIONAL HIERARCHY

The general organizational structure of the Navy Medical Department is consistent with the system employed throughout the Department of the Navy. Within this system the organizational hierarchy is separated into levels of descending responsibility known as echelons. At echelon 1 is the Chief of Naval Operations and his supporting staff, collectively referred to as OPNAV and addressed by codes such as OP-01. The next subordinate level, echelon 2, is composed of major components of the operating forces such as Commander in Chief Pacific Fleet and major elements of the shore establishment life the Chief of Naval Personnel. At echelon 3 are found primary sub-units of each echelon 2 command, for instance the Commander Naval Surface Force Pacific Fleet or Commander Naval Recruiting Command. Below echelon 3 are individual field activites such as bases or operating units such as ships or squadrons. Appendix A provides more detailed information on the Navy's internal organizational system. [Ref. 3:p. 9-2]

1. Director of Naval Medicine (OP-093)

Responsibility for developing policy for all medical department activities of the Navy and Marine Corps resides at echelon 1 with the Director of Navy Medicine, OP-093. The Director, also known as the Surgeon General, is a Navy Medical Corps Vice Admiral directly subordinate to the Chief of Naval Operations (CNO). [Ref. 4:p. I-5] The

Director also functions as the chief advocate and representative of the Navy Medical Department in its dealings with other entities within the Navy, other services, the Office of the Assistant Secretary of Defense, Congress, and the private sector. The relationship with the Defense Department is significant in that the Office of the Assistant Secretary of Defense, Health Affairs, [OASD(HA)] may bypass the normal chain of command, as depicted in Appendix B, and deal directly with the Director and the Surgeons General of the Army and Air Force regarding matters of common interest to the medical departments of the three services. In his capacity as principal advisor for medical matters to the CNO and Commandant of the Marine Corps, the Director maintains oversight of what are essentially two basic health care delivery systems. One is composed of medical assets functioning as integral components of the operating forces of the Navy and Marine Corps while the other consists of a world-wide network of shore based medical/dental treatment facilities.

a. Operating Forces

Health delivery resources in the operating forces are fully integrated into the command and control structure of those forces. These health care resources include ship and squadron medical departments as well as medical units generic to the Fleet Marine Force such as medical battalions and hospital companies. The Commanders in Chief

Pacific and Atlantic Fleets control the medical assets of all afloat and Fleet Marine Force units assigned to their respective Fleets. Command and control below the Fleet level is split between type commanders and numbered fleet commanders. Within the operating forces system, each major command, i.e., Pacific Fleet, Military Sealift Command, has a surgeon and dental officer who exercise technical guidance authority over all health care delivery units within the command. With regard to the operating force, the role of the Director of Navy Medicine is limited to the provision of technical and broad policy guidance rather than direct commannd and control. [Ref. 5]

b. Shore Based Facilities

Command and control of the shore based health care delivery system is exercised at echelon 2 by the Commander, Naval Medical Command, a medical department flag officer directly subordinate to the Director of Navy Medicine. Navy Medical Command consists of a headquarters activity, henceforth referred to as MEDCOM, seven echelon 3 "mission specific" commands, and eight echelon 3 geographical medical commands (GEOCOMS). [Ref. 4:p. I-5]

2. Commander, Naval Medical Command

MEDCOM headquarters is responsible for policy execution in all subordinate level commands within medical department claimancy. This responsibility is divided functionally among five deputy commanders; Financial Management (MEDCOM 01), Fleet Readiness and Support (MEDCOM 02),

Health Care Operations (MEDCOM 03), Readiness and Logistics (MEDCOM 04), and Personnel Management (MEDCOM 05). [Ref. 4: p. I-11]

The seven "mission specific" commands are the Naval Health Sciences Education and Training Command (HSETC), Naval Medical Research and Development Command, Naval Environmental Health Center (NEHC), Naval Aerospace Medical Institute (NAMI), Naval Medical Material Support Command (NMMSC), Naval Medical Data Services Center (NMDSC), and the Naval Ophthalmic Support and Training Activity (NOSTRA).

Each of the eight GEOCOM commanders is responsible to the Commander, Navy Medical Command for the operation of Medical Department claimancy direct care medical and dental treatment facilities within their region. Appendix C depicts the relationships of the various commands comprising Naval Medical Command.

3. Geographical Command

The GEOCOM commander is supported by a staff organized into four major subgroups, each directed by an assistant chief of staff. The subgroups consist of Resource Management, Logistics, Plans and Operations, and Denistry. [Ref. 4:p. I-15]

A GEOCOM may consist of several hospitals, outpatient clinics, and dental treatment facilities spread over a significant area and serving a varied beneficiary population. Reporting relationships within a GEOCOM may vary.

Naval Hospitals are usually echelon 4 activities reporting directly to the GEOCOM commander. Some regions with many closely located outpatient clinics have established an echelon 4 Medical Clinics Command, directly under the GEOCOM. In those situations where only one or two small outpatient clinics have been established relatively close to naval hospitals the clinics may be designated echelon 5 commands under the hospital's cognizance.

4. Naval Hospital

Naval hospitals are normally organized along functional lines with five directorates reporting to the commanding officer via an executive officer. Directorates are established for Administration, Medical Services, Surgical Services, Nursing Services, and Ancillary Services. Directorates are further subdivided into departments with each department head responsible to the director for the operation of his or her respective area. [Ref. 4:p. I-17]

C. PLANNING, PROGRAMMING, AND BUDGETING SYSTEM

The Planning, Programming, and Budgeting System (PPBS) is a tool employed by the Department of Defense to determine the manpower, material, and fiscal requirements necessary to achieve a desired lever of national security. The process develops general long term goals and specific goals for each fiscal year through a series of planning activities incorporated into an eighteen month cycle. The cycle can be broken down into three phases. The time sequence and major

contributors to PPBS within the Department of the Navy can be found in Appendix D. [Ref. 6:pp. A-10 - A-14]

1. Planning

During the planning phase of the cycle the nature of the threat facing the nation is assessed, a strategy is developed and guidance is provided to each of the services for use in the program development.

a. Threat Assessment

The threat assessment is a review of intelligence regarding present and future threats to national security. The assessment is carried out by the President, National Security Council, Joint Chiefs of Staff, and other key members of the Department of Defense.

b. National Strategy

Based on the threat assessment the Joint Chiefs of Staff develop a strategy, theoretically unconstrained by fiscal considerations, in the form of the Joint Strategic Planning Document (JSPC) and submit their recommendations to the Secretary of Defense. The JSPD identifies and "ideal" force structure to address the threat.

c. Secretary of Defense Guidance

From the JSPD the Secretary of Defense prepares the Defense Guidance. Defense Guidance is intended to provide a bridge between the planning and programming phases of PPBS. It is composed of three sections which address policy goals and objectives, programming goals and objectives, and

fiscal guidance to be used by the services to develop their five year defense plans. The first section of Defense guidance is fiscally unconstrained and focuses on broad policy goals for addressing the threat. The second section is fiscally constrained and is intended to identify program objectives to be incorporated into the services defense plan. The third section provides the fiscal guidance or limits within which the services must develop programs to achieve their objectives in meeting the threat.

2. Programming

During the programming phase the JSPD is translated into program force structures which incorporate time-phased requirements for manpower, material, and fiscal resources. It is during this programming phase that decisions on the desired composition of the services for the next five fiscal years are made.

a. Five Year Defense Plan

The Five Year Defense Plan (FYDP) summarizes all defense programs approved by the Secretary of Defense for a period spanning five years into the future. It specifically delineates manpower and fiscal requirements needed by fiscal year for each program and serves as the template used by planners at the service and sponsor level for long term planning decisions.

b. Program Objective Memoranda

Using the framework provided by the JSPD and Defense Guidance the Secretary of the Navy issues his own

guidance to the major resource sponsors within the Department of the Navy. For the Navy, resource sponsors consist of subdivisions of the office of the CNO such as OP-099 for training or OP-093 for medical. The sponsors forward this guidance to major claimants, e.g., Commander Naval Medical Command, and direct them to draft program recommendations for areas of the strategy within their cognizance. Recommendations from Navy claimancies are submitted for review to the CNO in the form of Sponsor Program Proposals (SPPs). These SPPs contain specific resource requirements needed to implement the program and reflect the impact of constraints on manpower, funding, and industrial capacity. Each SPP is reviewed within the Office of the CNO, OP-096. Following this review, a CNO Program Analysis Memorandum (CPAM) is prepared which addresses the influence of each SPP on the Navy's capability to carry out its overall goals and objectives and highlights the areas within the program proposals requiring a decision by the CNO Executive Board (CEB). Program proposals are approved and prioritized by the CEB and adjustments are made to ensure conformance with constraints outlined in Secretary of the Navy Guidance. The results is a package known as the Program Decision Summary (PDS). Upon approval by the CNO and the Secretary of the Navy the PDS and the corresponding package from the Marine Corps is consolidated to form the Navy Program Objective Memorandum (POM) and submitted to the Secretary of Defense.

c. Joint Program Assessment Memoranda

After receiving POM submissions from each of the services, the Secretary of Defense forwards them to the Joint Chiefs of Staff for comparison of force recommendations with the previously developed threat assessment and national strategy goals. The result of the analysis if the Joint Program Assessment Memorandum (JPAM) which provides the Secretary of Defense with the Joint Chiefs views on the balance and capabilities of the POM force, the support levels necessary to implement the force, and its impact on the allocation of national resources.

d. Program Decision Memoranda

After consideration of the POM submissions of each of the services and the JPAM from the Joint Chiefs the Secretary of Defense makes program decisions which, following an opportunity for reclama by the services, are issued as Program Decision Memoranda (PDM).

3. Budgeting

The budgeting phase is the translation of the results of the planning and programming process into an annual funding requirement.

a. Budget Estimates

Following receipt of the finalized PDM the individual services prepare and submit updated estimates for the budget year to the Secretary of Defense. The budget year is defined as the fiscal year subsequent to the current year and represents the first year of the FYDP.

b. Decision Package Set

The budget estimates received by the Secretary of Defense are consolidated and issued as Decision Package sets for inclusion as the Defense portion of the President's Budget.

D. INPUTS TO THE MANPOWER AND BUDGET REQUIREMENTS DETERMINATION PROCESS

The process for determining manpower and budget requirements for activities within the Navy shore establishment, including naval hospitals, was historically limited to experience based estimates made by senior level planners. The tremendous growth in the size and complexity of the Navy subsequent to World War II and the growth in acceptance in many quarters, including the Congress, of industrial engineering techniques precipitated a shift toward a more quantitative and objective planning and programming process. The appointment of Robert MacNamara as Secretary of Defense in 1961 and his almost immediate implementation of the PPBS program for budget development spurred efforts within the Department of Defense and each of the services to develop analytical approaches for determining manpower, budget and other resource requirements. The ultimate objective of this drive was the development of a system through which a resource requirement generated within the lowest echelon within a particular service to accomplish a specific mission could be precisely quantified and identified within the overall Defense budgeting process.

This effort to systemize the resource requirements process continues nearly twenty-five years later. The task of developing effective programs for an organization as large and diverse as the Department of Defense has proven to be a difficult one. Each of the services has undertaken a number of approaches with varying degrees of success. in addition, for functions within the services with some degree of commonality such as shore based medical support, the Department of Defense has sought to implement programs which provide a degree of central management or monitoring. The result of these efforts has been the creation of a sizable number of data collection and reporting requirements for individual commands, eminating from a variety of sources. Each of the requirements is designed to support the resource requirements determination process at some level in the chain of command. The programs which provide data intended the manpower and budget requirements process for a naval hospital to be broken down into Navy-wide requirements, OASD(HA) mandated programs, medical department-wide initiatives, and other Department of Defense projects.

1. Navy-wide Programs

In the years prior to 1964, the Navy relied heavily on the experience, judgment, and assumptions of senior officials, rather than credible measurement and projection techniques, in the preparation of budget requests. In the eyes of Congress, these subjective proposals failed to support

the reasonableness of the Navy's request and major program cuts became frequent.

Since 1964, the Navy has attempted to employ a number of service-wide industrial engineering based resource requirements determination programs. These efforts began with the Navy Manpower Validation Program (1964-1969) which was superceded by the Navy Manpower Survey Program (1969-1973). Both programs determined requirements primarily through the use of interviews and historical data rather than more rigorous and reliable measurement techniques. Their major failing was that they identified temporary manpower requirements which became obsolete in an environment of frequent changes in mission or variations in the kind and amount of work being done.

Continuing Congressional pressure led the Navy to begin development, in 1972, of a more effective system for determining and justifying its shore based manpower needs. This system, known as SHORSTAMPS (Shore Requirements, Standards, and Manpower Planning System), was officially adopted in 1976.

The SHORSTAMPS program employed work measurement techniques in the determination of total shore manpower requirements for military, civilian, and contractor personnel to accomplish a particular mission or function. Its objectives were to:

-determine, document, and maintain quantitative and qualitative manpower requirements necessary to perform Navy support missions ashore

-report manpower requirements having a high degree of credibility

-redistribute manpower authorizations to match documented tasking and workload; and

-provide a manpower management capability to assist major users of personnel in the planning and programming process. [Ref. 7:p. 7]

The coupling of SHORSTAMPS standards with appropriately validated workload taskings was intended to provide a definitive statement of the manpower required to accomplish that workload. Appendix E provides a detailed description of the SHORSTAMPS program. [Ref. 7:pp. 49-53]

Dissatisfaction with the progress of SHORSTAMPS lead to the approval of an alternative, the Shore Manpower Documents (SHMD) program, incorporated under the aegis of the Navy Manpower Engineering Program (NAVMEP). The Navy expects SHMD to succeed where SHORTSAMPS has failed because SHMD is aimed at providing a more centralized organization, accomplishing methods-improvement studies, and the accelerated development of staffing standards. By relying on the strategy of accelerating the development of staffing standards the Navy projects NAVMEP service-wide coverage of all manpower requirements by the spring of 1987. [Ref. 7:p. 4]

The primary focus of NAVMEP, particularly with respect to shore activities, is on the determination of peacetime manning requirements. Requirements for mobilization and wartime manning were felt to be dependent upon the particular contingency being addressed. This belief led to the

development and implementation in 1979 of the Navy Manpower Mobilization System (NAMMOS).

a. Navy Manpower Engineering Program

The Navy Manpower Engineering Program (NAVMEP) was formally established in 1983 with the primary objective of supporting the PPBS process through the development of manpower authorizations which relate directly to funded programs. The failure of SHORSTAMPS to achieve more than 38% implementation coupled with the development of the Ship and Squadron manpower document programs, Commercial Activities Program (CA), Management Engineering Program (ME), and the Navy Manpower Mobilization System (NAMMOS) mandated an effort to improve or redesign failing programs and streamline the manpower requirements determination process. NAVMEP became the umbrella which encompassed SHORSTAMPS' successor, SHMD, and the other manpower programs.

The thrust of NAVMEP is to produce manpower requirements based on the most efficient operation/organization (MEO) achievable. Resource adjustments, both increases and decreases, needed to implement MEO manpower requirements are effected, via PPBS, by the CNO's Director of General Planning and Programming (OP-090) after the review and concurrence of the CNO's manpower resources sponsor (OP-01).

Upon its full implementation in 1987, authorizations for civilian or military manpower will only be included in the POM when a requirement has been validated by NAVMEP. [Ref. 7:pp. 1-1 - 1-3]

With the exception of the Ship and Squadron Manpower Document programs, a naval hospital is responsible for implementing all of the requirements of NAVMEP.

(1) Shore Manpower Document. SHMD was developed with the objective of assisting in the determination, documentation, and maintenance of quantitative and qualitative manpower requirements. The program further seeks to enable commands to report credible manpower requirements which could be employed to redistribute manpower authorizations to match documented tasking and workload.

The heart of the SHMD program is the Efficiency Review Process (ER), and the use of industrial engineering and management analysis techniques for determining the most efficient and effective means of operations (MEO) for single activity or group of functionally related activities.

Once the MEO has been identified SHMD employs two main subsystems to identify requirements: Shore Required Operational Capability (SHOROC), a dictionary of standardized statements which identify the kind and amount of various tasks accomplished by a shore activity; and, the Staffing Standards subsystem, a group of mathematical algorithms, based on industrial engineering studies and historical performance, which relate to various levels of workload. Integrating the two subsystems is the Navy Manpower Requirements System (NMRS), a data processing capability that determines minimum manpower requirements. [Ref. 7:p. 7]

Implementation of SHMD at an activity consists of five phases: a preliminary phase in which a feasibility study is conducted; a data gathering phase; a computation phase, during which staffing standards are developed; an assessment pahse; and implementation of the standards. Appendix F provides a more explicit explanation of each of these phases. [Ref. 8:p. IV-1]

(2) Commercial Activities. CA is an effort by the Executive Branch to improve the economy of commercial and industrial type operations within the government through the use of private contractors. OMB Circular A-76 (Revised) provides the authority for federal agencies to determine whether certain functions can be performed at a lower cost by the private sector than they can be accomplished inhouse. Under this program a government entity must compare its estimate of costs with competitive bids submitted by potential contractors. The government agency is then required to implement the least cost alternative.

To date, application of CA within naval hospitals has been limited to base operation functions such as security and housekeeping. Functions related to the provisions of clinical services have been excluded.

Implementation of CA is ongoing. The potential the program presents for decreasing budget requirements and affecting manpower requirements within all naval shore activites, including hospitals, makes it an important component of NAVEMP. [Ref. 9]

(3) Management Engineering. The ME program is directed at identifying methods of either increasing the effectiveness and capabilities of shore activites without increasing the resources employed or producing the same level of productivity with less resources through the use of industrial engineering principles.

Studies performed under the ME program focus primarily on identifying applications of word processing technology to improve efficiency through what are known as Word Processing/Administrative Support feasibility studies (WP/AS) or on improvement of management activities through the use of Management Advisory studies (MA).

ME was designed to function as a source for consultation and support. Studies are only accomplished at the request of individual activity commanders. [Ref. 10:p. IV-1]

b. Navy Manpower Mobilization System (NAMMOS)

NAMMOS is a system designed to provide planners and programmers with a means of determining scenario specific mobilization manpower requirements. By design, each scenario requires a set of functions to be accomplished. The workload associated with each function is used to generate manpower requirements. These manpower requirements are categorized on the basis of the nature of the function or skill, immediacy of the requirement, and the availability of manpower. NAMMOS was designed to make maximum use of

existing data bases and is intended to be fully compatible with SHMD. [Ref. 11]

2. OASD(HA) Mandated Programs

Two programs of increasing relevance to those seeking to determine resource requirements for naval hospitals arose from the findings of a study of the military health care delivery system mandated by President Nixon in 1973. The study, completed in 1975 by the Department of Defense, Department of Health Education and Welfare, and the Office of Management and Budget, sought to address four areas: physician shortages resulting from the end of the "doctor draft"; the quality of the systems for planning, management, and evaluation; the increase in overhead and support costs; and, the social equity of military health care and its compatibility with national health objectives. What the study identified, however, was a total lack of comparability, within and between the services and facilities, of health care cost and efficiency measurements, and manpower justification policies. The Uniform Chart of Accounts (UCA) and Uniform Staffing Methodologies (USM) are efforts to correct those deficiencies. [Ref. 12:pp. 3-9]

a. Uniform Chart of Accounts

UCA is designed to provide a standard for measurement and communication of costs between and within each of the three service medical departments, between individual facilities, and with the private sector. This commonality

of definitions for workload, cost elements, and work centers is intended to facilitate comparisons of performance within facilities, within each service, between the services, and with private facilities with the objective of improving efficiency and effectiveness of the Department of Defense health care delivery system.

Under UCA, expense and workload data are assigned to one of six functional categories representing Inpatient Care, Ambulatory Care, Dental Care, Ancillary Services, Support Services, and Special Programs. Each of the functional categories is further subdivided into summary accounts for specific work centers. Appendix G outlines the use of the subdivisions in collecting cost data. The intent of this hierarchy is the establishment of a viable mechanism for identifying costs and providing a documented basis for budget formulation. [Ref. 13]

b. Uniform Staffing Methodologies

The goal of USM is the implementation of a system of determining and justifying requirements for medical manpower to staff fixed medical and dental treatment facilities operated by the three military medical departments. In addition, the system should provide a mechanism to compare the efficiency of manpower utilization between the services.

Under USM, activities are divided into work centers for workload measurement purposes. Hours of work are summarized by type of provider: officer; enlisted; civilian;

or volunteer then broken down into five functional categories: clinician; direct care professional; registered nurse, direct care para-professional; or admin/clerical/logistic/other. The process for summarizing, assigning, and reporting hours of work is outline in greater detail in Appendix H. Within each category, hours of work are converted into full-time equivalent (FTE) manmonths and reported quarterly to OASH(HA) and MEDCOM. The workload data for the respective work centers are reported via UCA, also on a quarterly basis. Both USM and UCA data are then used to develop program estimating equations (PEEs) with formulae and coefficients specific to each individual service medical department.

It is not the purpose of USM to supplant the SHMD process. Instead, USM is meant to be a complimentary system to provide aggregate manpower data for planning at the Department of Defense and Naval Medical Command level. It is intended that naval activities continue to rely on SHMD to provide detailed data for determining program requirements. For example, changes in workload for a particular work center such as increases in prescriptions issued, would be applied to PEEs for that function by MEDCOM to determine macro requirements for pharmacy personnel. The individual command should employ SHMD methodology to determine specific grade and specialty requirements, e.g., one lieutenant pharmacist and three HM2 pharmacy technicians. [Ref. 14]

3. Medical Deparment-wide

In addition to programs mandated by higher authorities, the Navy Medical Command has also developed several internal methodologies for collecting data and determining resource requirements. While the collection of historical workload data, submission of budget calls, and use of managerial judgment and experience all predate PPBS and the era of engineered program requirements, they continue as sources of information in the resource requirements determination process.

a. Historical Workload Data

In addition to data collected and submitted to OASD(HA) and MEDCOM in compliance with the requirements of UCA and USM, all naval treatment activities, including naval hospitals, collect and report data on morbidity and mortality, clinic visits, admissions, average daily patient loads, prescriptions issued, lab studies, radiographic films taken, etc., to the Navy Medical Data Services Center (NMDSC) for compilation. The data have been published quarterly since 1945 in Statistics of Navy Medicine and distributed to all medical activities by MEDCOM. In addition, annual compilations of the same data are distributed to involved commands. [Ref. 15]

b. Budget Calls

The Budget Call is the document which initiates the budgeting process for Operations and Maintenance funds

within naval activities. Its purpose is to provide information from the field activity level to the upper echelons in the budgeting process.

Major claimants, such as Naval Medical Command, direct field activities to annually provide budget data for a period spanning three fiscal years. The first year being the year currently in progress and referred to as the Prior Year. Prior Year budget data serves as a base. The second fiscal year in the Budget Call is the budget currently before Congress and is called the Apportionment Year since it is intended to assist in the apportionment of funds to be appropriated by Congress. The third fiscal year for which information is requested is the Budget Year, the year for which the PPBS cycle is about to begin.

Field level comptrollers initiate a local level Budget Call from department heads within the activity. These submissions are consolidated by the comptroller and used to develop the Command's budget submission to the major claimant.

At the major claimant level, subordinate level budget submissions are to be used to prepare the response to the CNO's Budget Call and for apportionment purposes. [Ref. 6:pp. D-5 - D-7] Appendix L is a sample of a MEDCOM Budget Call.

c. Judgment and Experience

The judgment and experience level of decision makers throughout the manpower and budget requirements

determination process is an important, yet intangible, element in the outcome of the process.

At the lowest echelons within the organization front line managers and supervisors have direct exposure to the operation of the naval hospital as a health care delivery organization. They are the source of much of the data which feeds systems such as NAVMEP, UCA, and USM and would be on the receiving end of changes brought about by them. For that reason they constitute a source for validating program performance at the micro level.

At each succeeding echelon within the organization the decision makers span of control increases as does his or her exposure to the functioning of the various support systems. The perception of the decision maker of the validity and usefullness of a particular program in identifying manpower and budget requirements when compared to his or her own best judgment will influence the level of support the program receives and therefore its successful implementation.

4. Other Department of Defense Inputs

Two other Department of Defense-wide programs provide sources of data for use in the resource requirements determination process, the Defense Enrollment/Eligibility Reporting System (DEERS) and the Civilian Health and Medical Program of the Uniform Services (CHAMPUS).

a. Defense Enrollment Eligibility Reporting System

Implementation of DEERS began in 1981 with two primary objectives: to compile an accurate data base of the population of personnel eligible to access Department of Defense programs such as health care, commissaries, and exchanges; and as a by-product of the first function, the elimination of fraudulent use of those services by ineligible personnel. The first objective is of primary significance to Navy health care planners because it constitutes the first attempt at compiling comprehensive data on the populations served by naval hospitals.

DEERS relies on a data base compiled from pay records of active duty and retired sponsors. Enrollment of dependents is accomplished by sponsors through submission of applications for dependent identification cards. The resultant data base provides planners with population and demographic data on eligible beneficiaries by zip code area based on sponsor location. The zip code zones within a forty mile radius of a naval hospital comprise its catchment area for determining potential demand for services. [Ref. 16:pp. 3-1 - 3-18]

b. CHAMPUS

CHAMPUS, in operation since 1966, is a program managed by the Department of Defense to share the costs of eligible beneficiaries seeking medical treatment from private sector providers and hospitals. The commanders of

individual naval hospitals are provided, on a monthly basis, with data concerning the number of non-availability statements issued within their catchment area. This data, accumulated by the Office of CHAMPUS (OCHAMPUS), gives an indication of the level of demand for inpatient care within the catchment area not being met by the naval hospital, whether due to limits in the facility's capacity or in the availability of particular clinical specialties. Information regarding the quantity and nature of outpatient services delivered to eligible beneficiaries within a particular catchment area is not as readily available to the hospital commander. While OCHAMPUS has access to data concerning the total quantity and specialty mix of outpatient care received through CHAMPUS, the naval hospital commander is provided only with a regular listing of providers in the local area who have indicated a willingness to participate in CHAMPUS and a gross dollar total of CHAMPUS outpatient expenditures by specialty. Specific information concerning the number of patients receiving care for a particular diagnosis is only available through local records maintained for patients counseled by the facilities health benefits advisors. The reports provided to MEDCOM concerning CHAMPUS utilization are essentially limited to duplicates of the reports received by individual facilities.

E. SUMMARY

This chapter has sought to familiarize the reader with the organizational structure of the Navy medical department and the formal programs developed at various levels to determine manpower and budget requirements for naval hospitals. In the next chapter the actual process for determing manpower and budget requirements for a naval hospital will be explored, with emphasis placed on identifying the contributions made by each echelon and the role of the formal programs in the final product.

III. DESCRIPTION OF THE PROCESS OF DETERMINING MANPOWER AND BUDGET REQUIREMENTS

This chapter described the process currently employed for determining manpower and budget requirements for a naval hospital. The description will attempt to illustrate the contributions of each echelon in the chain of command to this process and identify the role played by the various programs discussed in the previous chapter. It begins at the naval hospital level and will show the activities and inputs at each successive echelon from the GEOCOM through MEDCOM, the major claimant, and on to OP-093, the resource sponsor.

A. NAVAL HOSPITAL

Within naval hospitals, the responsibility for determining manpower and budget requirements resides with the commanding officer. A key element of the commanding officer's responsibility for managing the facility is the identification of whether the hospital is staffed with the appropriate number and mix of personnel to efficiently accomplish its mission and whether the fiscal resources allocated to the command are sufficient to fund ongoing activities. The responsibility for day-to-day management of manpower and fiscal resources are delegated to the heads of the Manpower Management and Fiscal Departments, respectively.

Manpower resources are allocated to individual commands via Manpower Authorizations (MPA) issued by the Deputy CNO for Manpower, Personnel, and Training (OP-01). The mechanism through which a command communicates the need for adjustments in numbers or mix of manpower is the preparation of Manpower Authorization Change Requests by the manpower management officer.

The identification of budget requirements for the command is accomplished through Budget Submissions prepared by the fiscal officer.

The next sections will explain the processes used by commands in preparing requests for changes to the MPA and for developing Budget Submissions.

1. Manpower Authorization Change Requests

Naval hospitals, like other Navy commands, are required to conduct annual reviews of manpower billet requirements. If this review identifies a need to increase or decrease the number of personnel at the command or reveals the requirement for modification of the mix of personnel assigned, for example the substitution of two pharmacy technicians for two operating room technicians, the command prepares a MPA Change Request. The request is forwarded to MEDCOM, the Manpower Claimant, via the GEOCOM. In addition to annual billet reviews, MPA Change Requests may be submitted when a command undergoes a change in mission or function, such as an increase in authorized bed capacity or the addition of a new clinical service. [Ref. 6:pp. 9-4 - 9-5]

The guidance provided to commands in The Manual of Navy Total Force Manpower, OPNAV Instruction 1000.16E, identifies SHMD as the basis for billets shown on the MPA and requires that any changes be supported by the appropriate Staffing Standard. [Ref. 6:pp. 2-18 - 2-19] However, the implementation by MEDCOM of only one of the forty-three staffing standards, identified by the GAO as applicable to the medical department, prevents compliance with that requirement by naval hospitals. [Ref. 7:p. 20] Instead, hospitals develop justification statements for each requested change based primarily on the judgment and experience of the commanding officer and his or her principal advisors combined with internally collected workload data and projections. In the case of requests for increases in manpower the justification must indicate whether the command has billets in a particular area which it considers to be in excess and which might serve as compensation for the requested increase. As an example, a command may wish to reduce the number of pediatrician billets it is currently authorized in compensation for a requested increase in the number of general surgeons authorized. The request also indicates the result of the proposed change on the command's mobilization manpower requirements.

The individual billet change proposals for the hospital are prioritized, with compensated requests receiving the highest priority, and submitted for review to the GEOCOM.

Appendix I is an example of typical MPA Change Requests for a small naval hospital. [Ref. 18]

2. Budget Submissions

Each fiscal year, typically in April or May, the fiscal officer at each naval hospital begins preparation of the Command's Budget Submission in anticipation of receiving the Budget Call from the GEOCOM.

In preparing the Budget Submission, the Fiscal Officer provides each of the department heads within the command with information regarding their current and previous years budget as well as cost data collected from their department via UCA. Using this information and their previous experience with the department's operations as a guide, the department heads prepare estimates for the Budget Year and the subsequent fiscal year. The estimates from the individual departments are reviewed and consolidated by the fiscal officer and submitted to the commanding officer for approval. Following the inclusion of adjustments mandated by the commanding officer, the approved estiamtes are used to form the Budget Submission forwarded in response to the GEOCOM Budget Call. Appendix J is an example of a portion of a Budget Submission prepared by a small naval hospital to fund direct health care operations. The Budget Submission can be most simply described as a command's financial plan for carrying out its peacetime health care delivery mission. [Ref. 18]

B. GEOGRAPHIC NAVAL MEDICAL COMMAND (GEOCOM)

As described previously, the GEOCOM commander is responsible for management and oversight of all fixed medical and dental treatment facilities within their region. In this capacity, the GEOCOM reviews all MPA Change Requests and Budget Submissions generated by subordinate commands. The commander is supported in this oversight process by the staff of the Assistant Chief of Staff for Resources Management (ACOS). Following the review process, the individual command submissions and associated endorsements are forwarded to MEDCOM for further evaluation and approval.

1. Manpower Authorization Change Requests

Cognizance of the review and evaluation of MPA Change Requests is maintained by the Manpower Analysis Branch of the Resource Management staff. The manpower analysts compare the impact of each request with historical, current, and projected mission and workload requirements. Strong emphasis is placed on the effect of the change on the Region as a whole. In the case of uncompensated requests from a particular command, an attempt is made to identify compensating billets elsewhere in the Region. If the change request is incorrectly prepared or if justification appears to be grossly insufficient, the request is returned to the originating command for correction or further substantiation. Following completion of the review, the requests are endorsed and, after approval by the commander, submitted to MEDCOM. [Ref. 17]

2. Budget Submissions

Oversight of fiscal activities within the GEOCOM is accomplished by the Comptroller Branch of the Resource Management Staff. A major responsibility of the Comptroller is the issuance of the annual Budget Call to subordinate commands. The Budget Call contains guidance and format instructions for the preparation of Budget Submissions disseminated by MEDCOM. A sample of a GEOCOM Budget Call is provided as Appendix K. It consists primarily of an endorsement and additional instructions attached to the MEDCOM Budget Call.

Upon receipt of the Budget Submissions, comptroller personnel review the overall reasonableness of the proposal with respect to historical, current, and projected mission and workload requirements of the individual command as well as previous budget and expenditure levels. When the review is completed, the submissions from the individual commands are compiled into a single package and, after approval by the commander, forwarded to MEDCOM [Ref. 18] Appendix L is a portion of the MEDCOM Budget Call for fiscal year 1986 and a sample GEOCOM Budget Submission.

C. NAVAL MEDICAL COMMAND

MEDCOM's capacity as the agent for policy execution for all health care delivery resources, exclusive of those allocated to the operating forces, requires that the process for determining manpower and budget requirements for naval hospitals be considered as only one segment of the overall resource determination mechanism.

With respect to manpower requirements, the needs of each individual hospital must be weighed against the needs of other health care delivery and support activities end strength limitations, and personnel availability. Decisions regarding manpower requirements involve the cooperative efforts of the staffs of the Deputy Commander for Readiness and Logistics, Personnel Management, and Health Care Operations.

The determination of budget requirements is less complex, in the sense that the budget figure arrived at for a particular hospital is essentially a translation of MEDCOM's projection of the facility's workload into a dollar value. This function is accomplished by the staff of the Deputy Commander for Financial Management.

1. Determining Manpower Requirements

The central coordination point for requests for changes to MPAs is the Manpower Division (MEDCOM-44) of the staff of the Deputy Commander for Readiness and Logistics (MEDCOM-04). The change requests forwarded from the hospitals by their respective GEOCOMs are routed to Health Care Operations (MEDCOM-03) and Personnel Management (MEDCOM-03) and Personnel Management (MEDCOM-05) for comments and recommendations. [Ref. 19]

The emphasis at MEDCOM-03 is the evaluation of whether or not the request is supported by current and projected workload as compared with the staffing of other facilities functioning at similar levels. The request must

also be consistent with goals established by MEDCOM for providing the appropriate scope and quality of care. The focus of the review by MEDCOM-03 is the impact of the proposal on the peacetime health care delivery mission.

At MEDCOM-05 the recommendations provided by MEDCOM-03 are compared with constraints imposed by limits in personnel availability and overall end strength. Change requests which contain proposals for compensation, either within the requesting command or as offered by the GEOCOM from another source, are examined to determine the effect of the change on existing billet levels. For instance, the proposal to offer a pediatrician billet as compensation for an increase of one general surgeon at a command must be matched with an excess authorization for a general surgeon and a shortage of one pediatrician elsewhere in the claimancy administered by MEDCOM. Uncompensated requests for billet increases which are supported by justification supplied by the command, the GEOCOM, and MEDCOM-03 must also be matched with a compensating excess within the claimancy. If an excess does not exist the approval for the change may be still recommended, contingent upon a future increase.

The staffed request is returned to MEDCOM-44 where the comments by the reviewing divisions are used to prepare an endorsement. After completion of the endorsement, which recommends either approval or disapproval, the change request is assigned a priority with respect to other change

requests forwarded by MEDCOM. The prioritized request is then submitted to OP-01 via OP-093. Requests which do not contain compensation for the proposed change must automatically be categorized in the lowest priority group. [Ref. 8: p. 9-3]

On occasion, a circumstance may arise where the initiative to modify the size or mix of personnel at a particular hospital begins within MEDCOM rather than at the field activity. For instance, the Direct Medical Care Division of MEDCOM-03 may desire to increase the number of obstetricians at Naval Hospital Long Beach is an effort to reduce the level of CHAMPUS expenditures within that catchment area. In such a case, the MPA Change Request developed by MEDCOM-03 would be staffed by the appropriate divisions, endorsed, prioritized, and forwarded in the same manner as a request initiated at a lower echelon. [Ref. 19]

2. Determining Budget Requirements

Budget requirements for naval hospitals are determined by MEDCOM-11, the Budget Division of the Deputy Commander for Financial Management (MEDCOM-11). Hospital fiscal requirements are identified within two activity groups in the overall MEDCOM budget. The 27 non-teaching hospitals are grouped with the 11 medical clinics and 150 branch clinics in the activity group Station Hospitals and Medical Clinics. The four teaching hospitals are funded under the activity group Care in Regional Defense Facilities. The process

followed by MEDCOM to arrive at budget estimates for both activity groups is the same.

The budget estimate is derived as an aggregate dollar amount to fund all commands or functions within the activity group. The process begins with the isolation of fixed and variable components in the previous and current fiscal year's expenditures. The estimate developed for the current year's fixed costs serves as a base for determining requirements for the Budget Year and four subsequent years. The fixed cost base is adjusted to reflect the projected inflation rate. Inflation adjusted estimates of each variable cost element are then added to arrive at a funding level considered to be sufficient to maintain the level of productivity achieved in the current year. This estimate serves as a new base which is then adjusted to provide for projected changes in workload or mission. [Ref. 20]

Workload is measured using the Composite Work Unit (CWU). [Ref. 21:p. 0-42-44] The CWU converts historical workload into a unit of output through the following formula:

$$CWU = OB + 10AD + 10LB + 0.3CV$$

where:

OB = Average Daily Occupied Beds

AD = Average Daily Admissions

LB = Average Daily Births

CV = Average Daily Outpatient Visits

The budget figure developed by MEDCOM-11 using the methodology described combines the experience and judgment of medical department planners with workload projections to arrive at an estimate of the cost of operating and maintaining the fixed medical treatment facilities used to accomplish the peacetime health care delivery mission.

The budget estimates for each of the seven activity groups under MEDCOM's cognizance are consolidated into a single budget package and submitted to the commander for review. Following his approval the package is forwarded to the resource sponsor, OP-093, to support development of the POM. [Ref. 20]

D. DIRECTOR OF NAVY MEDICINE (OP-093)

The resource requirements determination process described up to this point has focused on the accomplishment of the peacetime health care delivery mission of maintaining the health of the active duty force and other eligible beneficiaries. At the OP-093 level, however, while budget planning emphasis remains concerned with funding peacetime requirements, manpower planning and programming efforts are directed almost entirely at the determination of wartime needs. The planning activity which results in the formulation of th manpower and budget requirements portion of the medical operations SSP occurs within the Resources Division (OP-931) of OP-093.

1. The Manning Strategy

As mentioned above, the aim of manpower planning activities in support of the POM is the identification and programming of the active duty portion of the medical department's wartime manning requirements. The force levels that eventually result from this process provide the resource base from which personnel needed to support peacetime requirements, such as staffing naval hospitals, are drawn.

a. Wartime Manning

The first step in determining wartime manning levels is to identify the Total Force manpower requirement, composed of active duty, selected reserve, and pretrained individual manpower (PIM). The priority for wartime manning is given to:

1. Marine Corps Support;
2. Deployable Medical Systems--Hospital Ships, Casualty Receiving Ships (LHA/LPH), Fleet Hospitals, Advance Base Functional Components (ABFC); and
3. Overseas Medical Facilities (OCONUS). [Ref. 22]

The active duty component of the Total Force consists of the number of personnel required to meet the manning requirements of the Marine Corps, Deployable Medical Systems, and the OCONUS facilities along with a minimum cadre necessary to maintian CONUS facilities until the arrival of selected reserve and other augmentees.

The size of the Total Force manpower requirement is derived through the use of casualty estimates generated

by the medical planning models (MPM) of the Joint Operations Planning System (JOPS). JOPS is a scenario based planning model developed by the Joint Chiefs of Staff. Combat force composition to meet the threats within various JOPS scenarios are used as the population at risk for the MPM. From the resultant casualty estimates treatment requirements at various levels of care ranging from the combat zone to CONUS are identified. CWUs are then used to compute the number and type of personnel needed to augment Marine Corps, deployable, OCONUS, and CONUS cadre units.

The active duty component of the Total Force developed in this process constitutes the medical manpower requirement included in the SPP for medical operations. [Ref. 22]

2. The Budget

The budget package provided to OP-093 by MEDCOM is translated almost directly by the Resource Division into the budget requirements portion of the SPP. Adjustments to the two Activity Groups financing medical operations of naval hospitals are limited to changes necessary to support manpower and equipment levels identified in the wartime planning process described earlier. Examples of these adjustments include increases in funding to procure additional beds and linen to support wartime bed expansion within hospitals or reduction in Operations and Maintenance funding levels because of the substitution of military nurses for

civilian nurses to improve flexibility to meet combat casualty care requirements.

The adjusted budget estimate is included in the SPP which, after approval by the Surgeon General, is submitted to the CNO for inclusion in the POM. [Ref. 22]

3. The CNO Executive Board (CEB)

As mentioned in the previous chapter, the SPP is subject to scrutiny by the CEB prior to inclusion as an item in the POM and eventual submission to Congress. The CEB evaluates the degree of conformity of the program proposed in the SPP with Defense Guidance and guidance issued by the Secretary of the Navy. Decisions by the CEB have a major impact on the funding and manpower levels for which appropriations will be sought. To understand the potential impact of CEB decisions, consider the following example.

In developing the manpower requirements level for a particular year OP-093 utilizes the MPM to identify a need for 700 medical officers, 900 nurses, 150 MSCs, and 12,000 corpsman, all of whom are currently on active duty, to staff the twenty Fleet Hospitals necessary to support a particular wartime scenario. Associated with this estimated manpower requirement is a budget request reflecting a level of funding necessary to enable the identified manpower to provide a particular level of peacetime health care to dependents and other beneficiaries. An interpretation of Defense Guidance by the CEB that mobilization support requirements, such

as medical care, are better met by a higher ration of selected reserves in the Total Force mix results in the decision to staff fifteen of the twenty Fleet Hospitals with selected reserves and PIM. The impact of this decision on the SPP is a significant reduction in projected end strength requirements for medical department manpower and budget requirements.

The SPP emerges from the CEB as a portion of the Program Decision Summary and is eventually included in the Navy POM. [Ref. 22]

E. ALLOCATION OF APPROPRIATED RESOURCES

The efforts to identify and justify manpower and budget requirements bear fruit in the form of funding and manpower levels appropriated by Congress. However, modifications to original program proposals by Congress and through earlier actions by the CEB, JCS, and the Department of Defense, result in appropriated funding and manpower levels which may differ substantially from proposals originally submitted by the claimant.

1. Allocation of Manpower

The major challenge in allocating manpower in the medical department is the process of mathcing strength and mix levels generated by OP-093 to support wartime requirements with needs identified by hospitals and other activities attempting to accomplish the peacetime health care delivery mission.

The allocation process relied upon by MEDCOM for distribution of manpower resources provided by OP-093 is heavily reliant on the judgment of planners and program managers. Changes in the levels of manpower authorized are distributed to various commands by MEDCOM-05 after consultation with MEDCOM-03 and other affected program managers through changes to MPAs. The overall objective of the process being an allocation policy which will provide the broad spectrum of care necessary to maintain essential wartime skills of the providers in a manner which is cost effective yet consistent with requirements for quality of care. In addition, emphasis is placed on lowering CHAMPUS expenditures in high cost areas.

As an example, an authorization for an increase of two obstetricians may be identified by MEDCOM-31 as a mechanism for reducing CHAMPUS expenditures in the Naval Medical Command Southwest Region. The GEOCOM would therefore be directed to initiate a request to increase the MPAs of one or more hospitals within the Region to reflect the change. The two physicians could then be assigned to the newly created billets.

2. Allocation of the Budget

Budget authority granted to MEDCOM by OP-093 is allocated directly to field activities such as naval hospitals by a process that closely mirrors the determination of the aggregate total developed for inclusion in the SPP.

An inflation-adjusted base is calculated from current year fixed and variable costs which is estimated to be capable of sustaining the same level of output. The base is adjusted to reflect projected changes in workload and mission. Following this initial allocation, any remaining funds are allocated on the basis of unfunded requirements identified by MEDCOM in the previous fiscal year. The completed Expense Operating Budget (EOP) for the upcoming quarter, with one to three percent held back for contingencies, is forwarded to the individual command via the appropriate GEOCOM. At the GEOCOM level, an additional contingency allowance is deducted and the quarter's obligation authority delivered to the subordinate command. [Ref. 20]

F. THE ROLE OF FORMAL PROGRAMS

In Chapter II several formal programs were described which were developed at various levels within the Department of Defense to support the process for determining resource requirements. During the course of this study an attempt was made to identify the contributions of each of those programs to the resource requirements process. It was found that while considerable effort is expended in meeting reporting requirements for each of them, the support they provide is limited.

1. NAVMEP

The individual programs reviewed under NAVMEP were Shore Manpower Documents (SHMD), Commercial Activities (CA),

Management Engineering (ME), and the Navy Manpower Mobilization System (NAMMOS).

a. Shore Manpower Documents

SHMD was found to play no significant role in the manpower requirements planning process at any echelon from the hospital to the OP-093 level. The most significant factor in this is the lack of implemented staffing standards to support the planning process. However, while a recent GAO study demonstrated that the use of staffing standards could result in the identification of increased manpower requirements in such areas as nursing and pharmacy support, it does not appear that the peacetime workload concentration of SHMD would result in increased billet authorizations given the wartime planning emphasis used to determine requirements at the OP-093 level. [Ref. 7:p. 16] In short, there is no direct linkage between peacetime shore requirements and the funded billets derived from the POM process.

b. Commercial Activities

Examination of the CA program within naval hospitals failed to identify that the program makes any contribution to the resource planning process. Decisions regarding which activities at the field level are to be reviewed for possible contract performance are made at the CNO level. The role left to resource requirements planners, from the claimant down, is the assessment of the impact of contract performance on military and civilian manpower levels

and O&M expenditures needed to fund the contracts. [Ref. 18]

c. Management Engineering

No evidence was found, neither from interviews with personnel involved in determining resource requirements nor in reviewing supporting documentation, that ME plays a significant role in the identification of manpower and budget requirements for naval hospitals.

d. Navy Manpower Mobilization System

The use of NAMMOS was found to be restricted to the Readiness Division (MEDCOM-41) within MEDCOM and OP-0931. In both areas it is employed in concert with the MPM and other contingency planning models to help in the identification of Total Force mix requirements. The level of support currently provided by NAMMOS appears to be restricted by the absence of SHMD Staffing Standards or viable NAMMOS Staffing Standards for medical functions. Due to the lack of either type of standard, NAMMOS is only capable of providing gross estimates of aggregate officer and enlisted manpower requirements. As a result, there is almost total reliance still being placed on the judgment and experience of manpower planners in determining specific specialty mix needs for given scenarios.

2. Uniform Chart of Accounts

UCA was the only program, of those reviewed in this thesis, which appears to be integrated into the planning

process. The program provides a mechanism for readily isolating cost data generated by various organizational components within the hospital. This cost data is used at the hospital level by the fiscal officer to assist department heads in the preparation of budget submissions. At MEDCOM, UCA cost data is used to develop budget estimates which support development of the SPP as well as assisting in arriving at the estimates used to make allocations after appropriations are received.

Several weaknesses exist in the use of UCA data for cost comparison and planning purposes. Perhaps foremost among them is the current use of fiscal year 1982 UCA data as the base for determining efficient expense levels. The problem arises due to the questionable validity of standards derived from data collected in the first full year of UCA implementation. The reliability of data collected in the early stages of a new program being understandably suspect. The second weakness is the lack of distinction in UCA cost categories between levels of intensity in services provided by various hospitals. Cost reported under UCA code AAA for an internal medicine occupied bed day for treatment of an 18 year old marine suffering from viral syndrome at Naval Hospital Cherry Point may differ significantly from the costs reported under the same code at Naval Hospital Bethesda for treatment of an 84 year old retired admiral suffering from cirrohsis complicated by diabetes.

3. Uniform Staffing Methodologies (USM)

Implementation of USM has yet to progress significantly beyond the data collection and reporting stage. The collection activities at the hospital level have frequently been delegated to very junior personnel who, while often very dedicated, may not be capable of ensuring a high degree of accuracy in data submitted to OASD(HA). During the course of the research for this thesis a significant level of activity was noted at the GEOCOM level directed at improving the the reliability of USM reporting. [Ref. 17]

The heart of USM's support of the process for determining manpower requirements is the development of Program Estimating Equations (PEE). A task that has yet to be completed. However, there is considerable concern whether the PEEs developed from the USM data collected to date would be worthwhile, and perhaps more importantly, if data derived soley from peacetime workload has any relationship to wartime manpower planning.

4. CHAMPUS

The reduction of CHAMPUS expenditures is a goal in palnning endeavors at the hospital, GEOCOM, MEDCOM, and OP-093 level. The problem to be overcome is the means of establishing a direct correlation between a specific change in manpower or budget level within a particular facility and a corresponding shift in CHAMPUS costs in that catchment area.

5. Defense Enrollment Eligibility Reporting System

The DEERS data base is currently in an early stage of development and specific population and demographic information has yet to be made available. However, the value of specific information regarding the population contained in an individual catchment area may be limited given the incremental nature of the manpower and budget requirements planning system employed by the Navy at the present time.

G. SUMMARY

This chapter has presented a description of the actual processes used by each of the echelons to determine manpower and budget requirements for a naval hospital and an overview of how allocations to field activities are made. In addition, it provides come insight into the extent the programs described in Chapter II are employed in this process.

The next chapter will try to give a view of the future utilization of the formal programs in planning decisions, based on their use to date, and summarizes the authors' conclusions derived from their limited research.

IV. CONCLUSIONS AND OUTLOOK FOR THE FUTURE

The previous two chapters reviewed the organizational structure of the medical department, the formal programs developed to support the determination of manpower and budget requirements, and the actual process within each echelon of the organization for determining those same requirements. The sections to follow will explore some of the reasons why the various programs are not fully employed and the prospects for their future use, the effect of the continuing evolution of the roles and responsibilities of each echelon on the determination of requirements, and the factors which influence how future decisions will be made.

A. THE CONTRIBUTIONS OF FORMAL PROGRAMS

The description, in Chapter III, of the actual activities at the various echelons which result in the determination of manpower and budget requirements revealed the limited contribution of formalized programs. It may be useful to explore the possible reasons why these programs receive such limited application and what the prospects are for their future use.

1. Navy-wide Programs

The Navy-wide programs that have been previously discussed fall under the umbrella of NAVMEP. Each of them has experienced different degrees of utilization.

a. Shore Manpower Documents

The availability of SHMD as a planning tool at any level within the medical department has been limited by the lack of implementation of Staffing Standards. The absence of Staffing Standards disrupts the linkage between measurement of workload and the identification of manpower requirements, the fundamental purpose of SHMD.

The failure to fully implement SHMD and the associated Staffing Standards, despite direction by the CNO, is not a problem unique to the medical department but is instead indicative of a number of concerns by managers in many communities throughout the Navy. The foremost concern being a suspicion that the engineered standards offer a great potential for supporting reductions in manpower requirements despite "actual needs" derived on the basis of the manager's first-hand experience with the organization's operations.

Whether current efforts to develop standards applicable to functions within the medical department will result in staffing stnadards which contribute to the identification of manpower requirements which support the POM are questionable. The current SHMD methodology seeks to define staffing needs based on peacetime workload and case mix, needs which may not translate into the quantity and mix of personnel needed to meet wartime requirements. For SHMD to efficiently support the determination of medical department manpower requirements this disparity needs to be

resolved. However, the ability of the medical department to resist the CNO's directive to implement SHMD may be at an end. While the need to plan for disparate wartime and peacetime missions is a unique problem not faced by most operational or shorebased commands outside the medical department, this difference appears to no longer serve as ample justification for noncompliance. The CNO has made a commitment to Congress that SHMD will serve as the Navy's mechanism for supporting manpower requirements and it seems inevitable SHMD will begin to paly a significant role in future medical department planning. Failure to comply will result in reductions in manpower throughout the medical department.

b. Commercial Activities

As mentioned in Chapter III, the impetus for initiatives involving the CA program comes from the CNO level. The result is that subordinate commands, from the claimant to the field activity function in a reactive mode with efforts limited to making adjustments in manpower and budget requests to compensate for CA induced changes. The focus of CA within the medical department activities has been directed at base operations type functions rather than on patient care areas. There is no indication that this focus will shift in the short term without a significant change instituted by the CNO or other higher authority.

c. Management Engineering

There is no indication that ME studies are recognized at any level in the medical department, as even a

subsidiary portion of the planning process. The application of word processing, a major emphasis of ME, has been widely recognized as a means of improving administrative efficiency. Efforts to install wordprocessing systems have begun, and most programs are implemented without use of the services offerred by ME.

The general management consultation services available to commanding officers through ME, are also available to naval hospitals through the staffs of the GEOCOM and MEDCOM. A tendency to keep problems inhouse or at least within the medical department will probably persist, just as the air community or surface community each seeks to rely on their particular sponsors for support.

d. Navy Manpower Mobilization System

The continued use of NAMMOS within MEDCOM and at the OP-093 level to assist in arriving at mobilization manpower requirements seems likely. The problem to be overcome is the development of staffing standards, either through SHMD or independently, which will enable the system to provide more than aggregate officer and enlisted totals. Such standards would allow the quantification of requirements in a manner more defensible in the budget process than the reliance on estimates based strictly on judgment and experience.

With the wartime health care delivery mission becoming the central factor in projecting resource requirements for the medical department, the information provided

by NAMMOS will continue to grow in importance. The continuing emphasis by Congress on the ability of the services to support their requests for resources with solid, objective, and defensible justification requires that NAMMOS be augmented by the development of rigorously engineered staffing standards. Such standards will result in force level and mix projections which are able to withstand the hard light of Congressional scrutiny.

2. OASD(HA) Mandated Programs

The two OASD(HA) mandated programs, UCA and USM, have achieved a greater degree of success in implementation than the other formal programs.

a. Uniform Chart of Accounts/Uniform Staffing Methodologies

The sponsorship and support of UCA and USM by OASD(HA) has assured that both programs have begun implementation at all levels within the Navy medical department. However, neither has yet to assume the major role in the planning and managing of resources for which they were developed. Neither program has been viewed as a significant tool at any level within the Navy medical department. This lack of solid commitment has been exemplified by very junior personnel being assigned in oversight and data collection positions at local commands and minimal staff support at the GEOCOM and MEDCOM levels. The result has been the collection of workload and expense data that is generally unreliable or at the least of dubious integrity. In the case

of UCA, the older of the two programs, the requirement to use UCA generated cost data as an efficiency measurement and as a basis for determining budget requirements has spurred efforts to improve the accuracy and reliability of collected data. USM is at a much earlier phase of implementation with efforts still concentrated on improving the procedures used for data collection. The next phase of USM implementation consists of the creation of PEEs by private contractors using data collected to date. PEEs derived from inaccurate data would be of little use in producing realistic projections of Navy medical manpower requirements and could result in significant embarrassment, to say the least, if scrutinized by Congress against a standard composed of long established Air Force PEEs.

While off to a somewhat rocky start, significant efforts are being expended to ensure a future place for both programs. UCA cost data has begun to be used at all levels to assist in the formulation of budget estimates for individual facilities. This role will expand with adoption of the Health Care Unit (HCU) as a replacement for the CWU as the measure of output and productivity. The HCU substitutes twenty-five weighted performance factors for the four employed by the CWU. It is believed that the HCU will better capture the variability of resource consumption in the delivery of a broad spectrum of patient care. The HCU performance factors are derived directly from the cost center

categories of UCA. Coincident with the adoption of the HCU by the Navy is the pending revision and consolidation of the UCA and USM governing instructions into a single directive. This merger, along with the creation of a single Medical Efficiency and Performance Report (MEPR), signals a continuing commitment by OASD(HA) to produce an effective program to facilitate monitoring and comparison of health care activities of the three services as well as the creation of a tool to improve the mechanism for programming and utilizing resources.

The ability of a successful UCA/USM program to match workload and costs with aggregate manpower requirements, particularly if complemented by realistic SHMD standards could give planners the information needed to translate changes in staff or funding into specific projections of changes in workload. Such a capability would provide objective, quantifiable, and defensible justification for estimates of manpower and budget resources needed to support the peacetime health care delivery mission.

3. Medical Department-wide Programs

The medical department-wide programs described in the previous two chapters are of a less formal nature but more an established part of the planning process than the other programs that were examined. But like the others, their contribution to the determination of manpower and budget requirements seems to be undergoing a change.

a. Historical Workload

Workload data collected from hospitals and other facilities through the morbidity and patient administration reporting systems have traditionally been a key element in the mechanism for programming and allocating resources. As confidence in the quality of information provided by UCA and USM increases, it is felt that the reliance on "tried and true" historical data will diminish for purposes of determining manpower and budget requirements. Morbidity data will eventually be relied upon primarily for the epidemiological purposes for which it was originally collected.

b. Budget Submissions

Budget Submissions prepared by hospitals and submitted to MEDCOM do not appear to be a contributing factor in the budget requirements determination process. The individual Budget Submissions are a compilation of estimates prepared by the department heads of each individual facility, tempered by the judgment of the fiscal officer and commanding officer. Because of the suspected variability in the reliability of the submissions, MEDCOM chooses to prepare its own estimates based on the hospital's established level of expenditures.

Subsequent to fiscal year 1986 MEDCOM will employ the Expense Limitation Holder (ELH) concept for allocating funds. Under the concept each of the eight GEOCOMs will receive a block of O&M funds for the operation of the facilities under their cognizance. [Ref. 22] From this block of

funds the GEOCOM will distribute Operating Targets (OPTAR) to each commanding officer. MEDCOM anticipates that funds will be allocated to the GEOCOMs using a methodology similar to the way funds are now allocated to hospitals. How the GEOCOMs intend to indentify requirements and make allocations has yet to be delineated. Under this program the accountability for violation of R.S. 3678 and 3679 regarding over expenditure or mismanagement of funds resides with the GEOCOM commander not the individual commanding officer. For that reason it is not unrealistic to assume an increased interest by each GEOCOM in the management of fiscal resources by local commands.

c. Judgment and Experience

Judgment and experience have become increasingly valuable attributes for managers who must develop defensible estimates of manpower and budget requirements despite noticable gaps left by incomplete or yet to be implemented portions of support programs like NAVMEP or UCA/USM. In addition they must contend with the vagueries of PPBS and the Congressional budget process. Unfortunately, the system which is relied upon to cultivate managers and leaders for the medical department has not emphasized quantitative analysis and decision making skills as selection criteria. Officers can progress from entry level to command without the benefit of formal education in management or even exposure to division officer or department head training programs employed by the line community to groom future leaders.

The result has been the rise of individuals, at all levels, who have not been suitably prepared for the demands of the environment in which they are to perform.

4. Other Department of Defense Programs

The other two Department of Defense programs discussed in Chapters II and III make only limited contributions to the resource requirements determination process and their future role is uncertain.

a. CHAMPUS

The limited nature of the information available to planners within the medical department regarding CHAMPUS utilization in a particular catchment area has reduced its role in the planning process to that of serving as a goal. Hospitals have been directed to reduce the number of non-availability statements issued and the amount of CHAMPUS expenditures in their particular areas by providing an expanded level of services inhouse. The difficulty that arises is the current lack of a means of identifying how changes in manpower and budget resoruces allocated to a given facility translates into a measurable impact on CHAMPUS costs.

The future role of CHAMPUS depends heavily on how the current shift in emphasis on basing resource requirements on wartime needs and the problem of providing care to those who cannot be served by military treatment facilities is resolved. The alternatives being considered run the gamut from government-owned contractor operated programs like

PRIMUS, to enrollment in existing prepaid HMO type health plans who provide care in contractor-owned and operated facilities. In either case, the impact on the manpower and budget requirements process is dependent on the extent such programs will be utilized by non-active duty beneficiaries and the resultant affect of a military treatment facility utilization.

b. Defense Enrollment Eligibility Reporting System

The DEERS program has yet to reach a stage of development which would enable the generation of reports on the population and demographics of individual catchment areas. However, even if such information was available, the current manpower and budget requirements determination process is not designed to employ population or demographic based projections in arriving at estimates of resource needs.

The future contribution of DEERS as a planning tool is uncertain. With the increasing emphasis being placed on developing the skills providers will need to perform effectively in their wartime roles, DEERS could offer some assistance in the identification of catchment areas which would provide the type of case loads needed to support the various specialties. For example, by applying known incidence rates to population data provided by DEERS, planners might find that the catchment area served by Naval Hospital San Diego generated a large number of potential neurosurgical patients. As a result, San Diego would receive the

highest priority for allocation of neurosurgeon billets in order to capitalize on the training opportunity provided by the local population.

B. EVOLUTION OF THE ORGANIZATIONAL STRUCTURE

The organizational structure of the Navy medical department, which underwent a major revision beginning in 1972, has yet to evolve into its final form. The roles and responsibilities of each of the echelons continue to shift as the result of efforts by senior managers to improve the management and efficiency of medical programs. Pressures for change have also been exerted from above, particularly of late, with the OASD(HA) directed shift in emphasis toward a concentration on improving wartime readiness. The sections to follow will touch on the nature of the changes going on within each echelon and the possible effects on the process for determining manpower and budget requirements.

1. Naval Hospital

A major impact of the reorganization of the medical department on naval hospitals was the creation of the GEOCOM as a mechanism for providing closer management control of the operation of individual facilities. The hospital commanding officer now finds that he or she is accountable to a flag officer located in close proximity whose span of control is small enough to allow individual attention to be provided to how each facility is being operated. The decentralization of the control of hospitals has provided an

opportunity to test new initiatives, like the ELH concept, as a means of developing more innovative management skills at the hospital level. From the information that is currently available it appears that each hospital commanding officer will work closely with the GEOCOM to develop an annual financial plan for the operation of the facility. The financial plan will then serve as a mechanism for assessing the command's effectiveness at employing budget resources to accomplish its mission.

Individual commanding officers will be able to work closely with the GEOCOM to develop financial plans tailored to support the specific needs of their commands. The flexibility which will be fostered in developing budget plans will also be encouraged in manpower planning. This growth in management skill is supported by the concentration of the oversight function for manpower and budget programs in a single Assistant Chief of Staff for Resource Management Division. The development of close cooperation between the hospitals and the GEOCOM can serve as a means to encourage the use of more quantitative planning techniques and enforcement of the requirements to implement programs such as SHMD and UCA/USM.

2. Geographical Naval Medical Commands

Since their inception, the GEOCOMs have steadily increased their influence in the management of the peacetime health care delivery mission. The ability of GEOCOMs in

some regions to assist local commands or influence decisions at the MEDCOM level was hampered initially by the perception that they were a staff in search of a mission. This perception has begun to change as the GEOCOMs developed and demonstrated the skills necessary to assume greater portions of the oversight of lcoal operations previously held by MEDCOM.

The trend toward decentralization of the day-to-day management of health care operations to the GEOCOMs has resulted in attempts to grant greater autonomy at the local level such as ELH. There is every indication that this trend will continue in other areas of resource allocation.

3. Naval Medical Command

The growing capabilities of the GEOCOMs to manage broad areas of the health care delivery mission should allow MEDCOM to divest itself of most day-to-day health care operations duties and allow the focus to shift to broad long-term management concerns. MEDCOM has been presented with the opportunity to assume the system command role for which it was created and concentrate on the challenges presented by the linkage of peacetime and wartime manpower requirements decisions and assuring adequate budget levels in an increasingly stringent funding environment. Perhaps greater emphasis can also be devoted to improving the reliability of NAVMEP and other programs and promoting the enforcement of their implementation.

4. Director of Navy Medicine

The emphasis currently being placed on the use of wartime requirements as the basis for determining the size and mix of the medical department has placed increasing importance on the role of OP-093. The staff of the Surgeon General has not only had to assume a major role in the planning of resource requirements and development of POM inputs but also has had to serve in somewhat of a diplomatic role in an effort to dispell the adversarial environment which had arisen within the Office of the CNO regarding medical programs prior to the reorganization. Their efforts appear to be meeting with some degree of success and OP-093 seems to be viewed increasingly as an integral part of the OPNAV organization and not simply as an appendage.

5. Secretary of the Navy

Interest at the level of the Secretary of the Navy level in medical programs has been increasing steadily over the past several years. It is possible that within the foreseeable future a position, such as an Assistant Secretary of the Navy for Health Affairs, could be created to provide oversight of medical department operations.

6. Assistant Secretary of Defense for Health Affairs

Recent initiatives within OASD(HA) to concentrate the determination of manpower requirements on satisfaction of the wartime health care delivery mission and the search for alternative means for delivering care to beneficiaries

who cannot be cared for in facilities staffed with this wartime mix of providers has the potential for creating major changes within all three service medical departments.

The challenge created for health care planners is the determination of how an active duty staff designed to satisfy wartime needs can be used efficiently to satisfy the peacetime health care delivery mission. The size of this new active duty force has yet to be determined and is reliant on decisions regarding employment of reserves, PIM, and others in the Total Force mix.

C. SUMMARY

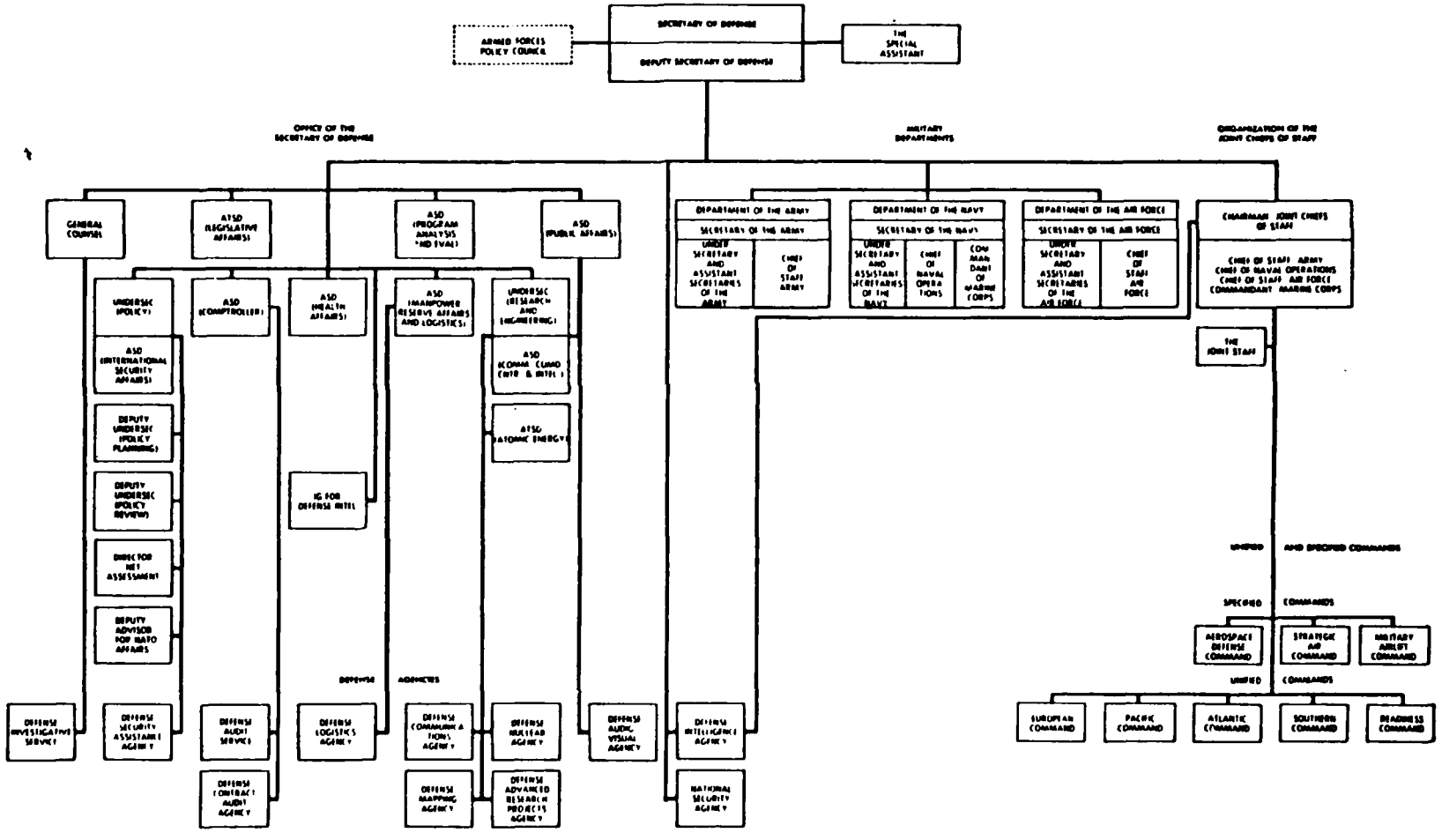
The Navy medical department faces a future environment in which the scrutiny of how resource requirements are determined and how those resources are allocated will become increasingly intense. The push toward deficit reduction measures, Congressional dissatisfaction with defense management practices, and the resultant increase interservice competition for defense dollars is going to reinforce the requirement for solid, defensible estimates of manpower and budget requirements.

The Navy medical department is faced with the opportunity to begin developing effective mechanisms for planning and allocating its resource requirements. It can also begin to take a proactive approach to employing programs mandated by higher authority such as NAVMEP. To do so will require the development of managers with the quantitative skills to

function in a competitive environment. If the medical department does not seize the initiative and begin to move forward, it will find that its destiny is controlled by entities within the Department of the Navy or OASD(HA) willing to fill the management void.

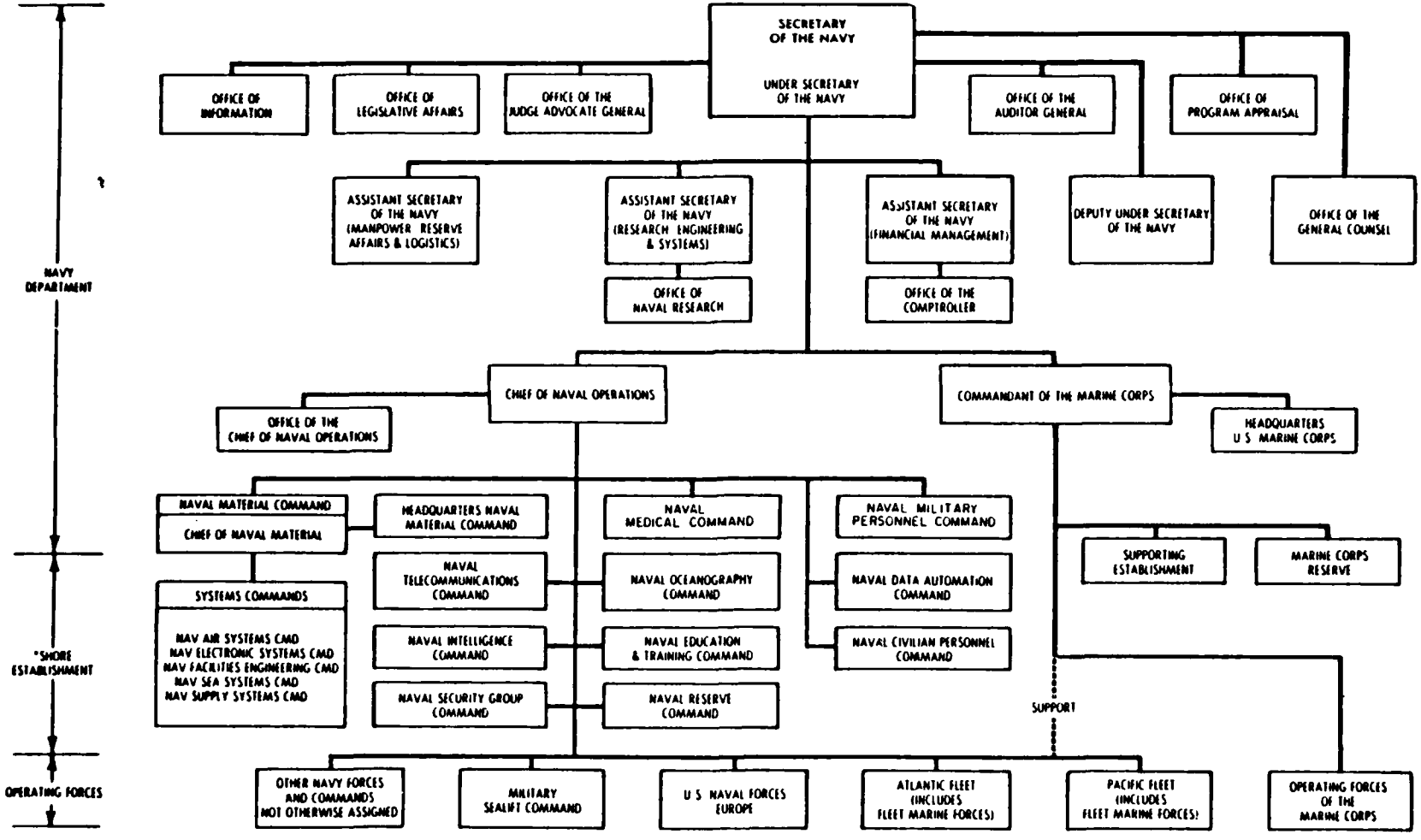
APPENDIX A

ORGANIZATIONAL CHART FOR DEPARTMENT OF DEFENSE



APPENDIX B

ORGANIZATIONAL CHART FOR THE DEPARTMENT OF THE NAVY



* Also includes other designated shore activities, not shown on the chart, which are under the command or supervision of many of the organizations depicted

APPENDIX C

MEDICAL DEPARTMENT REPORTING ECHELONS

CHAIN OF COMMAND—BY ECHELON

Echelon	*Chain of Command*
1	*CHIEF OF NAVAL OPERATIONS*
2	*CHIEF OF NAVAL PERSONNEL*
5	Commanding Officer, Navy Recruiting District, Cleveland, Brookpark, OH
5	Commanding Officer, Navy Recruiting District, Columbus, Columbus, OH
5	Commanding Officer, Navy Recruiting District, Michigan, Detroit, MI
5	Commanding Officer, Navy Recruiting District, Indianapolis, Indianapolis, IN
5	Commanding Officer, Navy Recruiting District, Louisville, Louisville, KY
5	Commanding Officer, Navy Recruiting District, Richmond, Richmond, VA
5	Commanding Officer, Navy Recruiting District, Pittsburgh, Pittsburgh, PA
5	Commanding Officer, Navy Recruiting District, Washington, Hyattsville, MD
4	Commander, Navy Recruiting Area Five, Great Lakes, IL
5	Commanding Officer, Navy Recruiting District, Chicago, Glenview, IL
5	Commanding Officer, Navy Recruiting District, Kansas City, Kansas City, MO
5	Commanding Officer, Navy Recruiting District, Milwaukee, Milwaukee, WI
5	Commanding Officer, Navy Recruiting District, Minneapolis, Minneapolis, MN
5	Commanding Officer, Navy Recruiting District, Omaha, Omaha, NE
5	Commanding Officer, Navy Recruiting District, St. Louis, St. Louis, MO
4	Commander, Navy Recruiting Area Seven, Dallas, TX
5	Commanding Officer, Navy Recruiting District, Albuquerque, Albuquerque, NM
5	Commanding Officer, Navy Recruiting District, Dallas, Dallas, TX
5	Commanding Officer, Navy Recruiting District, Denver, Denver, CO
5	Commanding Officer, Navy Recruiting District, Houston, Houston, TX
5	Commanding Officer, Navy Recruiting District, Little Rock, Little Rock, AR
5	Commanding Officer, Navy Recruiting District, New Orleans, New Orleans, LA
5	Commanding Officer, Navy Recruiting District, San Antonio, San Antonio, TX
4	Commander, Navy Recruiting Area Eight, San Francisco, CA
5	Commanding Officer, Navy Recruiting District, Los Angeles, Los Angeles, CA
5	Commanding Officer, Navy Recruiting District, San Diego, San Diego, CA
5	Commanding Officer, Navy Recruiting District, Portland, Portland, OR
5	Commanding Officer, Navy Recruiting District, San Francisco, Oakland, CA
5	Commanding Officer, Navy Recruiting District, Seattle, Bellevue, WA
4	Officer in Charge, Navy Recruiting Exhibit Center, Washington, DC
4	Officer in Charge, Navy Recruiting Orientation Unit, Orlando, FL
1	CHIEF OF NAVAL OPERATIONS
2	COMMANDER, NAVAL MEDICAL COMMAND
3	Commander, Naval Medical Command National Capital Region, Bethesda, MD
4	Commanding Officer, Naval Hospital, Bethesda, MD
4	Commanding Officer, Naval Hospital, Patuxent River, MD
4	Commanding Officer, Naval Medical Clinic, Annapolis, MD
4	Commanding Officer, Naval Medical Clinic, Quantico, VA
4	Commanding Officer, Naval Dental Clinic, Bethesda, MD
3	Commander, Naval Medical Command Northeast Region, Great Lakes, IL
4	Commanding Officer, Naval Hospital, Great Lakes, IL
4	Commanding Officer, Naval Hospital, Groton, CT
4	Commanding Officer, Naval Hospital, Newport, RI
4	Commanding Officer, Naval Hospital, Philadelphia, PA
4	Commanding Officer, Naval Medical Clinic, Portsmouth, NH
4	Commanding Officer, Naval Dental Clinic, Great Lakes, IL
4	Commanding Officer, Naval Dental Clinic, Newport, RI
4	Commanding Officer, Naval Dental Clinic, Philadelphia, PA
3	Commander, Naval Medical Command Southeast Region, Jacksonville, FL
4	Commanding Officer, Naval Hospital, Corpus Christi, TX
4	Commanding Officer, Naval Hospital, Jacksonville, FL
4	Commanding Officer, Naval Hospital, Millington, TN

Echelon	*Chain of Command*
1	*CHIEF OF NAVAL OPERATIONS*
2	*COMMANDER, NAVAL MEDICAL COMMAND*
4	Commanding Officer, Naval Hospital, Orlando, FL
4	Commanding Officer, Naval Hospital, Pensacola, FL
4	Commanding Officer, Naval Medical Clinic, Key West, FL
4	Commanding Officer, Naval Medical Clinic, New Orleans, LA
4	Commanding Officer, Naval Dental Clinic, Jacksonville, FL
4	Commanding Officer, Naval Dental Clinic, Orlando, FL
4	Commanding Officer, Naval Dental Clinic, Pensacola, FL
3	Commander, Naval Medical Command Mid-Atlantic Region, Norfolk, VA
4	Commanding Officer, Naval Hospital, Beaufort, SC
4	Commanding Officer, Naval Hospital, Camp Lejeune, NC
4	Commanding Officer, Naval Hospital, Charleston, SC
4	Commanding Officer, Naval Hospital, Cherry Point, NC
4	Commanding Officer, Naval Hospital, Portsmouth, VA
4	Commanding Officer, U. S. Naval Hospital, Guantanamo Bay, Cuba
4	Commanding Officer, U. S. Naval Hospital, Roosevelt Roads, PR
4	Commanding Officer, Naval Medical Clinic, Norfolk, VA
4	Commanding Officer, Naval Dental Clinic, Camp Lejeune, NC
4	Commanding Officer, Naval Dental Clinic, Charleston, SC
4	Commanding Officer, Naval Dental Clinic, Norfolk, VA
4	Commanding Officer, Naval Dental Clinic, Parris Island, SC
4	Commanding Officer, U.S. Naval Dental Clinic, Roosevelt Roads, PR
3	Commander, Naval Medical Command Northwest Region, Oakland, CA
4	Commanding Officer, Naval Hospital, Bremerton, WA
4	Commanding Officer, Naval Hospital, Lemoore, CA
4	Commanding Officer, Naval Hospital, Oak Harbor, WA
4	Commanding Officer, Naval Hospital, Oakland, CA
4	Commanding Officer, Naval Medical Clinic, Seattle, WA
4	Commanding Officer, Naval Dental Clinic, Bremerton, WA
4	Commanding Officer, Naval Dental Clinic, San Francisco, CA
3	Commander, Naval Medical Command Pacific Region, Barbers Point, HI
4	Commanding Officer, U. S. Naval Hospital, Guam, Mariana Islands
4	Commanding Officer, U. S Naval Hospital, Okinawa, Japan
4	Commanding Officer, U. S Naval Hospital, Subic Bay, Luzon, RP
4	Commanding Officer, U. S Naval Hospital, Yokosuka, Japan
4	Commanding Officer, Naval Medical Clinic, Pearl Harbor, HI
4	Commanding Officer, U. S Naval Dental Clinic, Guam, Mariana Islands
4	Commanding Officer, U. S Naval Dental Clinic, Okinawa, Japan
4	Commanding Officer, Naval Dental Clinic, Pearl Harbor, HI
4	Commanding Officer, U. S Naval Dental Clinic, Subic Bay, Luzon, RP
4	Commanding Officer, U. S. Naval Dental Clinic, Yokosuka, Japan
3	Commander, Naval Medical Command Southwest Region, San Diego, CA
4	Commanding Officer, Naval Hospital, Camp Pendleton, CA
4	Commanding Officer, Naval Hospital, Long Beach, CA
4	Commanding Officer, Naval Hospital, San Diego, CA
4	Commanding Officer, Naval Medical Clinic, Port Hueneme, CA
4	Commanding Officer, Naval Medical Clinic, San Diego, CA
4	Commanding Officer, Naval Dental Clinic, Camp Pendleton, CA
4	Commanding Officer, Naval Dental Clinic, Long Beach, CA
4	Commanding Officer, Naval Dental Clinic, San Diego, CA
3	Commander, U.S Naval Medical Command European Region, London, England
4	Commanding Officer, U. S. Naval Hospital, Naples, Italy
4	Commanding Officer, U. S. Naval Hospital, Rota, Spain
4	Commanding Officer, U. S. Naval Dental Clinic, Naples, Italy
3	Commanding Officer, Naval Aerospace Medical Institute, Pensacola, FL

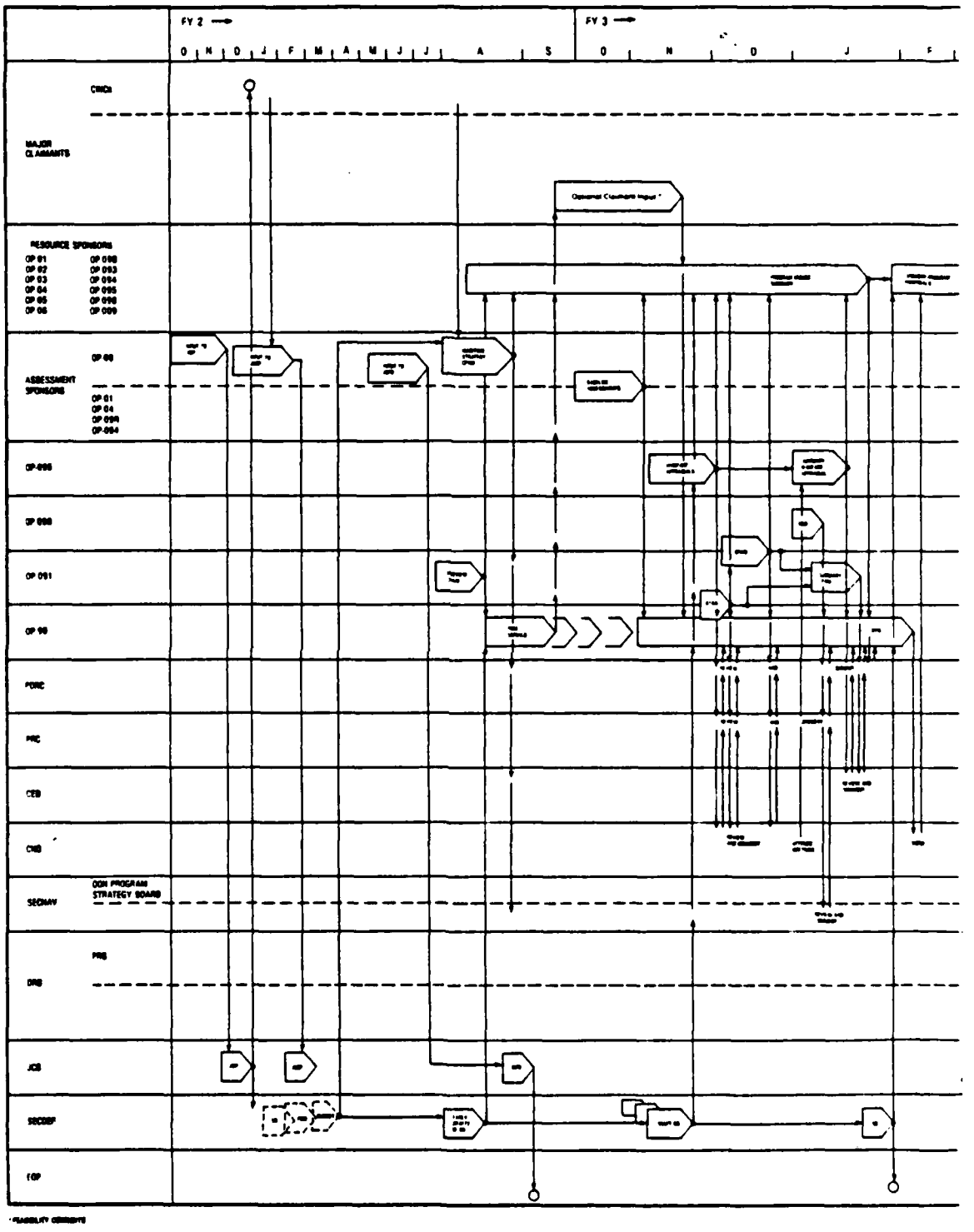
CHAIN OF COMMAND—BY ECHELON

Echelon	*Chain of Command*
1	*CHIEF OF NAVAL OPERATIONS*
2	*COMMANDER, NAVAL MEDICAL COMMAND*
3	Commanding Officer, Navy Environmental Health Center, Norfolk, VA
4	Officer in Charge, Navy Disease Vector Ecology and Control Center, Alameda, CA
4	Officer in Charge, Navy Disease Vector Ecology and Control Center, Jacksonville, FL
4	Officer in Charge, U. S. Navy Environmental and Preventive Medicine Unit No. 7, Naples, Italy
4	Officer in Charge, Navy Environmental and Preventive Medicine Unit No. 2, Norfolk, VA
4	Officer in Charge, Navy Environmental and Preventive Medicine Unit No. 6, Pearl Harbor, HI
4	Officer in Charge, Navy Environmental and Preventive Medicine Unit No. 5, San Diego, CA
3	Commanding Officer, Naval Health Sciences Education and Training Command, Bethesda, MD
4	Commanding Officer, Naval School of Health Sciences, Bethesda, MD
4	Commanding Officer, Naval School of Health Sciences, San Diego, CA
4	Commanding Officer, Naval Hospital Corps School, Great Lakes, IL
3	Commanding Officer, Naval Ophthalmic Support and Training Activity, Yorktown, VA
3	Commanding Officer, Naval Medical Data Services Center, Bethesda, MD
3	Commanding Officer, Naval Medical Materiel Support Command, Philadelphia, PA
3	Commanding Officer, Naval Medical Research and Development Command, Bethesda, MD
4	Commanding Officer, Naval Aerospace Medical Research Laboratory, Pensacola, FL
4	Commanding Officer, Naval Biodynamics Laboratory, New Orleans, LA
4	Commanding Officer, Naval Dental Research Institute, Great Lakes, IL
4	Commanding Officer, Naval Health Research Center, San Diego, CA
4	Commanding Officer, Naval Submarine Medical Research Laboratory, New London, Groton, CT
4	Commanding Officer, Naval Medical Research Institute, Bethesda, MD
4	Commanding Officer, U. S. Naval Medical Research Unit No. 2, Manila, Republic of the Philippines
4	Commanding Officer, U. S. Naval Medical Research Unit No. 3, Cairo, Arab Republic of Egypt
1	CHIEF OF NAVAL OPERATIONS
2	COMMANDER, NAVAL SECURITY GROUP COMMAND
3	Director, Communications Security Material System, Washington, DC
3	Director, Navy Courier Service, Alexandria, VA
3	Commanding Officer, Naval Security Group Activity, Adak, AK
3	Commanding Officer, Naval Security Group Activity, Anchorage, AK
3	Commanding Officer, U.S. Naval Security Group Activity, Athens, Greece
3	Commanding Officer, U.S. Naval Security Group Activity, Augsburg, Germany
3	Commanding Officer, U.S. Naval Security Group Activity, Philippines, Republic of the Philippines
3	Commanding Officer, Naval Security Group Activity, Charleston, SC
3	Commanding Officer, Naval Security Group Activity, Northwest, Chesapeake, VA
3	Commanding Officer, U.S. Naval Security Group Activity, Edzell, Scotland
3	Commanding Officer, Naval Security Group Activity, Fort George G. Meade, MD
3	Commanding Officer, U.S. Naval Security Group Activity, Galeta Island, Republic of Panama
3	Commanding Officer, Naval Security Group Activity, Groton, CT
3	Commanding Officer, U.S. Naval Security Group Activity, Guantanamo
3	Commanding Officer, U.S. Naval Security Group Activity, Hanza, Okinawa Prefecture, Japan
3	Commanding Officer, Naval Security Group Activity, Homestead, FL
3	Commanding Officer, U.S. Naval Security Group Activity, Sinop, Turkey
3	Commanding Officer, U.S. Naval Security Group Activity, Keflavik, Iceland
3	Commanding Officer, Naval Security Group Activity, Key West, FL
3	Commanding Officer, U.S. Naval Security Group Activity, Misawa, Japan
3	Commanding Officer, U.S. Naval Security Group Activity, Naples, Italy
3	Commanding Officer, Naval Security Group Activity, Pearl Harbor, HI
3	Commanding Officer, U.S. Naval Security Group Activity, Pyontaek, Republic of Korea
3	Commanding Officer, U.S. Naval Security Group Activity, Sabana Seca, PR
3	Commanding Officer, U.S. Naval Security Group Activity, San Vito Dei Normanni, Italy
3	Commanding Officer, Naval Security Group Activity, Skaggs Island, Sonoma, CA

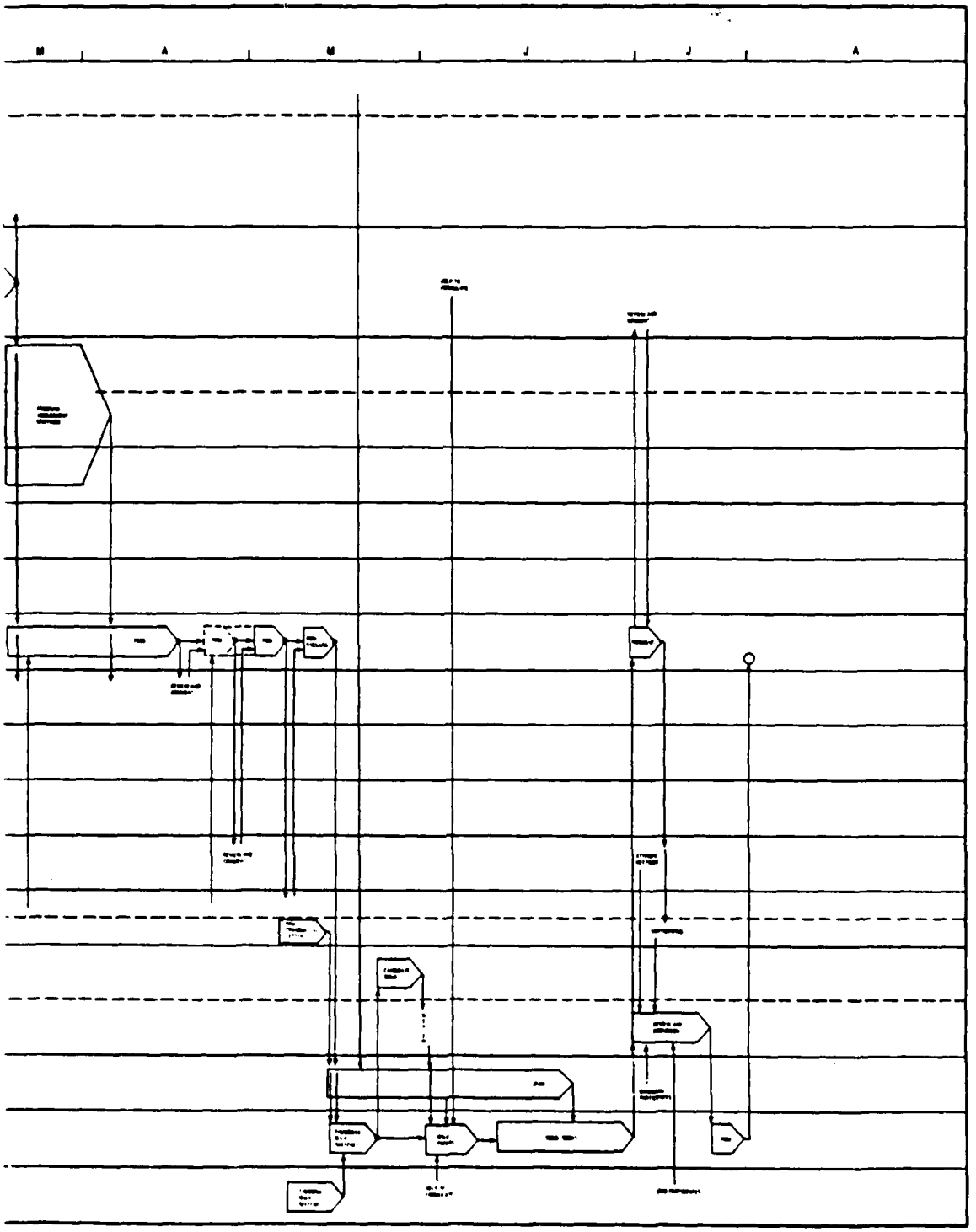
APPENDIX D

NAVY PPBS PROCESS

NAVY PPBS: PLANNING -



- PROGRAMMING PHASES

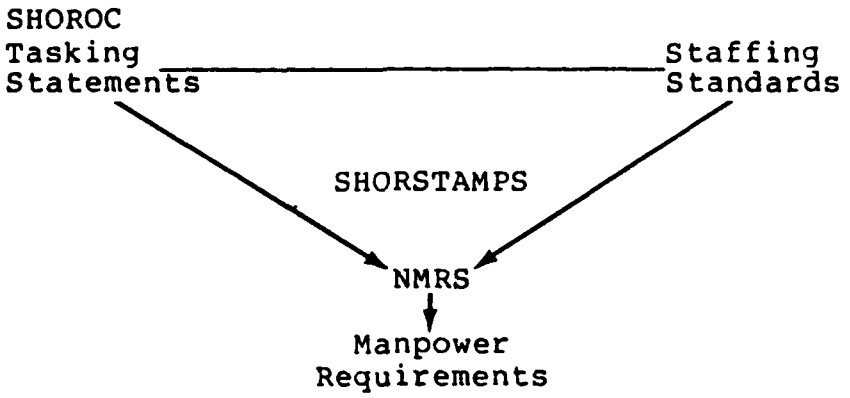


APPENDIX E

DESCRIPTION OF THE SHORSTAMPS PROGRAM

SHORSTAMPS is composed of two subsystems: a "Shore Required Operational Capability" (SHOROC) subsystem and a staffing standards subsystem. The Navy Manpower Requirements System (NMRS), a data processing capability, integrates the two subsystems to calculate minimum manpower requirements. The following diagram shows the interrelationship of the SHORSTAMPS subsystems.

Interrelationship of the SHORSTAMPS Subsystems



SHOROC subsystem

The SHOROC subsystem provides the basis for the development of staffing standards and, ultimately, for the determination of the minimum quantity of personnel required to do specific jobs. In essence, SHOROC is a dictionary of standardized and quantified tasking statements which identify the kinds of tasks done and how much of each kind is done at individual Navy shore establishments. The subsystem is designed to project known changes in Navy tasking and to separate mission-essential tasks from those which may be deferred because of insufficient resources or other constraints.

The SHOROC subsystem is divided into four hierarchical elements:

--Mission areas are broad categories or major subdivisions of the overall shore establishment's missions, such as supply, aircraft maintenance, financial and medical services, and ship repair.

--Functional areas are the various functions performed within each mission area, such as providing ancillary supply services, performing intermediate level maintenance on designated aircraft, and providing internal medicine services.

--Required functional capabilities (RFC) are the specific tasks performed within functional areas--such as operating an enlisted dining facility, operating a shop store, and issuing recruit clothing--which are specific tasks (i.e., required functional capabilities) within the functional area of providing ancillary supply services.

--Parameter values are quantifications of how much of each required functional capability is done in terms of the the quantity, frequency, and duration of work performed--such as average rations fed per month and total serving lines operated per week--which quantify the workload associated with operating an enlisted dining facility.

An example of the SHOROC elements associated with operating a Navy enlisted dining facility are shown below:

SHOROC Subsystem Elements

Element	Designator	Description
Mission area	SUP	Provide supply management and administrative control; procure, receive, account for, store, issue, and control material; and perform ancillary services.
Functional area	SUP04	Provide ancillary supply services.
Required functional capability	SUP04.012	Operate an enlisted dining facility.
Parameters		Serve an average of 9,100 rations monthly using a total of 21 serving lines per week.

The magnitude of the SHOROC subsystem is immense. As of January 1984, the subsystem included 26 shore establishment mission areas, 302 functional areas, and 6,068 required functional capabilities with from 1 to 6 parameters per RFC.

The SHOROC subsystem is dynamic, and periodic changes to it are required on a continuing basis to adjust for changes in tasking, workload variations, erroneous input, and the subsystem processes for standards development.

Staffing standards subsystem

The staffing standards subsystem uses SHOROC tasking information to develop mathematical equations or algorithms that translate workload data into expressions of quantitative and qualitative manpower requirements. Teams from the Navy Manpower and Material Analysis Centers in Norfolk and San Diego develop standards for particular SHOROC functions.

In developing staffing standards, individual standard equations are produced for tasks that are reasonably the same. The tasks are normally grouped together into what is called a "work center," and an equation is developed for each work center. The work center is a grouping of workers who use similar machines, processes, methods, and operations and who perform homogeneous work, usually located in a centralized area. A work center normally equates to a required functional capability in the SHOROC subsystem, but it may also equate to a combination of such capabilities within a functional area or to a total functional area. Standard equations covering closely related work centers may be grouped together and published as one staffing standards report.

In developing a standard, workload factors may appear that are unique to certain locations and that have a significant impact on the staffing requirement. In these cases, "additive" standards are developed to handle the special requirements and to identify major differences, such as special requirements because of location, climate, or tenant-support demands. The differences must be significant enough to make it impractical to use a single standard for all work centers.

The standards-development subsystem recognizes that developing a staffing standard is not a one-time effort. The estimated useful life of a staffing standard is from 2 to 5 years. Once a specific standard has been developed, it must be updated to maintain currency on the way tasks and functions are being performed. For this reason, standards-development policy includes provision for frequent updating of existing standards.

The technical aspects associated with the development and implementation of staffing standards are complex and time-consuming. According to manpower analysis center officials, this process generally takes from 30 to 36 months.

The development of staffing standards has three phases: preliminary, measurement, and computation. During the preliminary phase, the staffing standards development team acquires as much knowledge as possible about the area to be studied, develops a study plan, and prepares for the measurement phase. Significant steps in the preliminary phase are

--establishment of liaison with program managers, major manpower users, and technical experts;

--orientation of work center personnel and operating officials;

--identification of work centers;

--development of work center descriptions;

--identification of work units and potential workload factors;

--selection of appropriate work measurement methods;

--selection of measurement locations;

--installation of a work-count system; and

--identification of potential management-improvement recommendations;

Once developed, the measurement plan is sent to those major commands expected to use the standard for their review and comment. The plan is concurrently field-tested ordinarily at no more than three shore activities and is revised as necessary.

The measurement phase consists of on-site visits to a statistical sample of shore activities to collect workload and manpower data according to the measurement plan. One or more work measurement techniques generally will be used: work sampling, time study, operational audit, predetermined time standards, and queuing (waiting line) theory. Through the use of these and other techniques, workload is measured in terms of staff hours. This information is then used in the computation phase to develop the standards equation.

During computation, the staffing standards team examines and analyzes the results of the measurement plan. All suspected variables for the function studies are put through a series of statistical tests to determine whether they do, in fact, have an impact on manpower requirements. Again, using statistical techniques, the staffing standard equation is developed. Staffing tables are then constructed showing the breakpoints for each incremental increase in manpower (see app. II for an example). These tables display quantity and quality of each manpower space and identify it as military only, civilian only, or either military or civilian.

Following computation, NMRS provides the automatic data processing to merge the staffing standards with the SHOROC tasking to calculate manpower requirements. This is called the application phase of staffing standards processing.

At the beginning of the application phase, NMRS produces a manpower requirements worksheet for each activity affected by the standards. NMRS applies the SHOROC information for each activity to the staffing standard equation and calculates a total staff-hour figure for each required functional capability. The total staff-hour figure is supplemented or adjusted for unique requirements associated with a particular activity and is then used to generate the correct number of positions. This information is listed on the manpower-requirements worksheet. Summary manpower-requirement worksheets are produced for each major command. Ultimately, the staffing standards report, activity worksheets, and summary worksheets are sent to the user commands for review and comment. The user commands indicate on the worksheets whether they wish to fill the positions with military or civilian personnel or to handle the work through contract.

During application, changes to the SHOROC dictionary may be necessary as a result of the work performed by the staffing standards development teams. In addition, the equations for the standards may be changed as a result of the user command's reviews.

When all necessary changes have been made, the final manpower-requirements document (shore manpower document) is produced. This document shows each affected activity's manpower requirements for each required functional capability covered by developed standards, and the number of authorized spaces to be covered by approved staffing standards.

A staffing standard is considered complete and ready for implementation when the application process is finished and when the CNO has approved the standard for use. "Implementation" means that commands using the manpower requirements as calculated by the standard must make a conscious decision to change or not to change activity manpower authorizations. Changes in these manpower authorizations can take place, in the short run, through reprogramming existing authorizations or, in the long run, through future budget requests for additional authorizations.

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APPENDIX F

SHORE MANPOWER REQUIREMENTS DEVELOPMENT PROCEDURES

401. General. This section provides general guidance on the phases of shore manpower requirements development and specific guidance on conducting the feasibility study.

402. Preliminary Phase. The first and most critical phase is the preliminary. In this phase, a feasibility study which forms the framework for staffing standard dvelopment and/or efficiency review is conducted. Section B provides specific guidance on the feasibility study. The final product of the preliminary phase is a plan for completing the rest of the study effort.

403. Data Gathering Phase. This phase consists of the following:

a. On-side data gathering to measure and record actual workload and determine through work study and work measurement the time required to accomplish the workload. Normally, 30 days prior to an on-site visit, each activity will be provided with visitor clearance information.

b. Data call for claimant input. Claimant/activities will be required to provide data within 90 days plus mailing time. The data call package includes work center descriptions, proposed SHOROC language, workload data collection forms, and a list of activities performing the function under study.

404. Computation Phase. In the computation phase, the measured data are used to develop the staffing standard equation. To ensure accuracy, the first step is analysis of man-hours (the time required to perform the work) and workload factors (how much workload is accomplished). Deviations from the norm are investigated and adjustments are made when justified. Various techniques are then applied to determine the relationship between man-hours and workload factors. The staffing standard equation is the model which best predicts manpower requirements based on information from the data gathering phase.

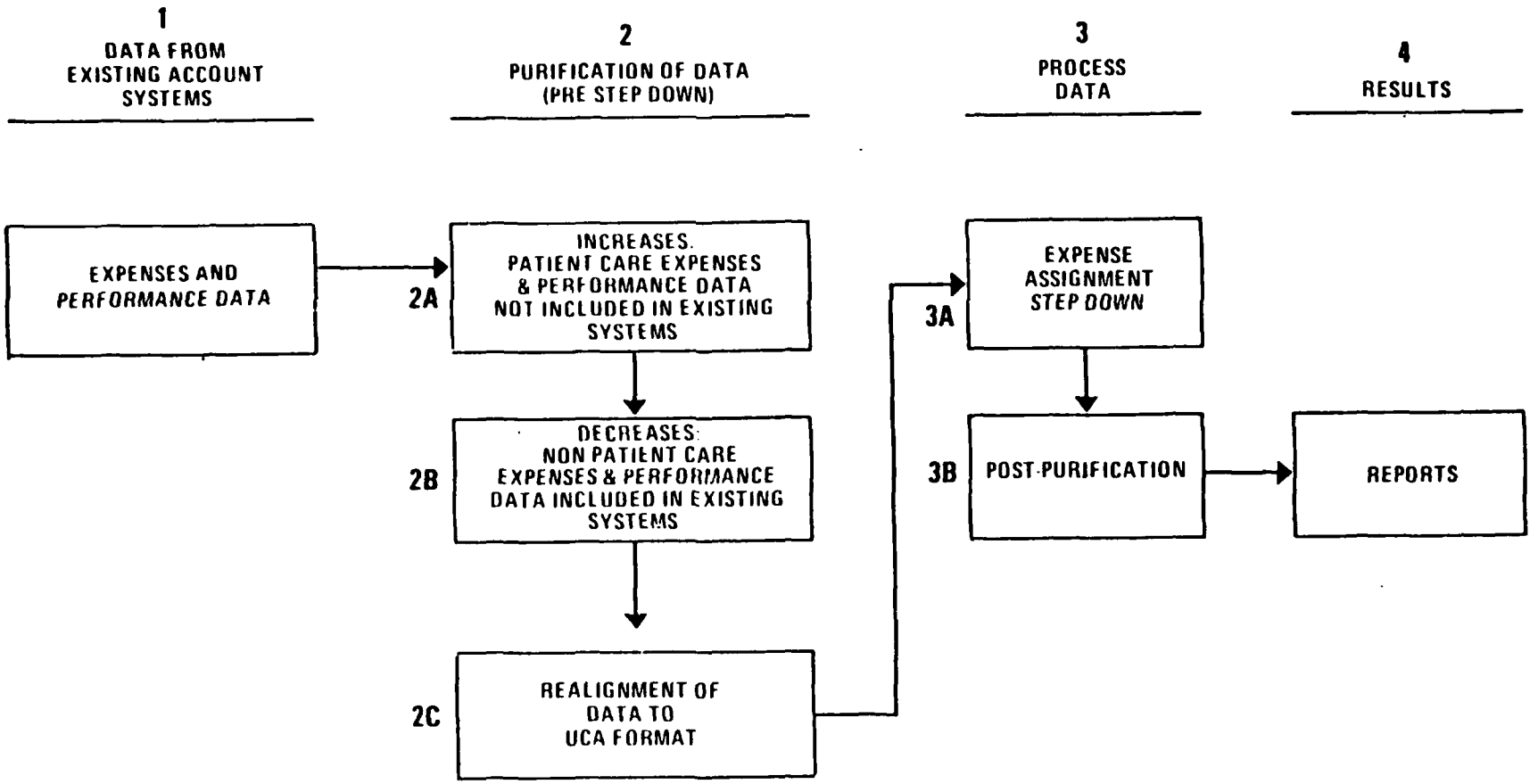
405. Assessment Phase. During this phase, manpower claimants, functional sponsors, and appropriate OPNAV staff offices will be requested to review and comment on staffing standard and/or ER report. Necessary changes will be validated and incorporated based on claimant, functional sponsor and OPNAV inputs. Part V provides additional detail on the assessment phase.

406. Implementation Phase. Implementation of staffing standards or individual activity MEO requirements will be directed by OPNAV. Part V further describes the standards implementation process.

407. Standards Maintenance. Development of a staffing standard is not a one-time effort. Once a standard has completed its initial development and has been approved, it must be maintained. Part VI describes the standards maintenance process.

APPENDIX G

DEPARTMENT OF DEFENSE
OVERVIEW OF UCA PROCESS



REPRODUCED AT GOVERNMENT EXPENSE

DoD Medical Performance Report

NAME OF FACILITY: _____ FACILITY CODE (UIC): _____ REPORT PERIOD: FROM _____ (YYMMDD) TO _____ (YYMMDD)

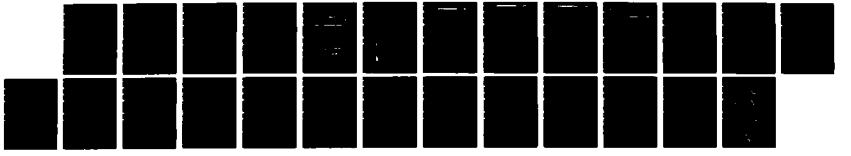
MAILING ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE) _____

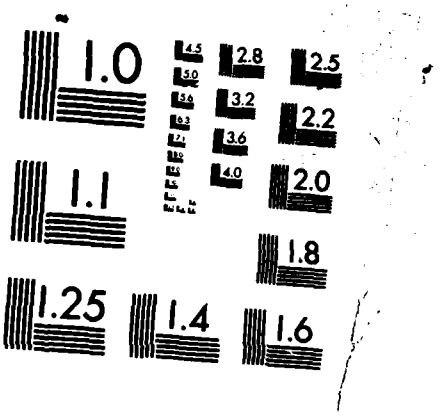
MILITARY MEDICAL REGION: _____ MILITARY DEPARTMENT: _____ ARMY _____ NAVY _____ AIR FORCE

CODE	TITLE	Specify Category ☐ CLINICIANS ☐ REGISTERED NURSES ☐ DIRECT CARE PARAPROFESSIONALS ☐ DIRECT CARE PROFESSIONALS ☐ ADMIN. CLERICAL LOGISTICS/OTHER					PERFORMANCE FACTOR	TOTAL
	INPATIENT CARE SECTION I	OFF	ENL	CIV	CNT	OTHER		
AAA	INTERNAL MEDICINE						OCCUPIED BED DAY	
AAB	CARDIOLOGY						OCCUPIED BED DAY	
AAC	CORONARY CARE						OCCUPIED BED DAY	
AAD	DERMATOLOGY						OCCUPIED BED DAY	
AAE	ENDOCRINOLOGY						OCCUPIED BED DAY	
AAF	GASTROENTEROLOGY						OCCUPIED BED DAY	
AAG	HEMATOLOGY						OCCUPIED BED DAY	
AAH	INTENSIVE CARE (MEDICAL)						OCCUPIED BED DAY	
AAI	NEPHROLOGY						OCCUPIED BED DAY	
AAJ	NEUROLOGY						OCCUPIED BED DAY	
AAK	ONCOLOGY						OCCUPIED BED DAY	
AAL	PULMONARY/UPPER RESPIRATORY DISEASE						OCCUPIED BED DAY	
AAM	RHEUMATOLOGY						OCCUPIED BED DAY	
AAZ	MEDICAL CARE NOT ELSEWHERE CLASSIFIED						OCCUPIED BED DAY	
ABA	GENERAL SURGERY						OCCUPIED BED DAY	
ABB	CARDIOVASCULAR AND THORACIC SURGERY						OCCUPIED BED DAY	
ABC	INTENSIVE CARE						OCCUPIED BED DAY	
ABD	NEUROSURGERY						OCCUPIED BED DAY	
ABE	OPHTHALMOLOGY						OCCUPIED BED DAY	
ABF	ORAL SURGERY						OCCUPIED BED DAY	
ABG	OTORHINOLARYNGOLOGY						OCCUPIED BED DAY	
ABH	PEDIATRIC SURGERY						OCCUPIED BED DAY	

AD-A164 949 THE PROCESS FOR DETERMINING THE MANPOWER AND BUDGET REQUIREMENTS FOR A NAVAL HOSPITAL(U) NAVAL POSTGRADUATE SCHOOL MONTEREY CA B G BRANNMAN ET AL. DEC 85 2/2

UNCLASSIFIED F/G 5/1 NL





MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963-A

APPENDIX I

SAMPLE MPA CHANGE REQUEST

JUSTIFICATION FOR RECOMMENDED CHANGES TO NAVAL HOSPITAL UNCOMPENSATED OFFICER MANPOWER AUTHORIZATION PRESENTED IN DESCENDING ORDER OF PRECEDENCE

1. BSC 04040 (2300K), Internal Review/Control Program Manager. Request authorization of one billet.

References: (a) NAVMEDCOMINST 7510.1
(b) SECNAVINST 5200.35
(c) MIDLANT ltr 0905: RJM:rhr 7500 18 APR 84
(d) MIDLANT ltr 7500 MIDLANT-0905, 11 JUN 84
(e) MIDLANT ltr 7500 MIDLANT-0905, 10 MAY 84

Per reference (a) the command is tasked with conducting audits, studies, analysis and evaluations of the functions identified in reference (e). Per references (b) and (c) the command is tasked with conducting vulnerability assessments and management control reviews of the functions listed in reference (e). Per reference (d) the command is required to accurately compile the manhours devoted to the efforts noted above. By actual count the command is required to inventory, review, assess and evaluate its performance in seventeen functional areas and fifty-eight assessible units while concurrently compiling the manhours devoted to this effort. Further, two semiannual reports on the status of the entire program must be compiled and reports on each review, assessment, inventory and evaluation must be prepared, approved and followed up. In order to appropriately manage the program the above request is submitted.

2. BSC 16220 (2100J), Director Quality Assurance. The authorization of this billet will ensure sufficient direction of the entire Quality Assurance Program throughout the command. He will serve as the physician advisor to the Quality Assurance Coordinator. The Director will ensure the Medical Staff's knowledge of, and participation in, both Quality Assurance and Risk Maangement activities throughout the command.

3. BSC 16240 (2300J), Quality Assurance Coordinator. The authorization of this billet will ensure sufficient coordination of the Quality Assurance Program throughout the command. The QA Coordinator is responsible for monitoring all Quality Assurance activities, tracking the status of problems identified through Quality Assurance activities, and for assuring communication between all departments and divisions in matters

relaed to Quality Assurance issues. In addition, he will prepare periodic reports for review by the Commanding Officer and the Executive Management Committee and provide assistance to each department, division or committee to ensure participation in the Quality Assurance process for problem identification, evaluation, review and resolution. The QA Coordinator will organize and maintain Quality Assurance Training Programs to ensure staff knowledge and understanding of Quality Assurance principles and processes.

4. BSC 16260 (2300J), Risk Management Coordinator. The authroization of this billet will ensure sufficient direction of the command's Risk Management Program. The Risk Manager will be responsible for identificaiton of patterns of incidents, claims and complaints as identified throughout the command. In addition, he will review and analyze all incident reports, patient complaints. . . .

Manpower Authorization Change Request

PCM ____
CLAIMANT ____
PROGRAM ELEMENT ____
RESOURCE SPONSOR ____
SPP SERIAL # ____
ISSUE TITLE ____

BSC HI/LOW ____

SUSPENSE CATEGORY ____
OPNAV 1000/2 PRINT ____
OPNAV 1000/2 TYPE ____
PHASED REORG DATE ____

AOC	ACTIVITY CODE	ACTIVITY NAME	TRANS NO.	FILES	UIC	DATE	PAGE
	3435-0225-00	Nav Hosp		X			1 of 1

T	AC	EFF DATE / AG'SAG	SEQ CODE	BILLET TITLE	DES/GR RATE	P NOBC P NEC PPLN / S NOBC S NEC	PSSP OCC SER / SSSP	PAQD GR / SAQD	PG BOC / LANG	MP / M S	PREV BSC / PREV UIC	S I	BA / CSR	CFY	FY 1	FY 2	FY 3	FY 4	FY 5	FY 6	S/R	M+1	M+2	M+3	M+6	M+12
B	NC	0000 mmmm	04040	INTERNAL REVIEW PROG MANAGER	2100 T				MPB			C	+1									+1 →				
U	NC	0000	16200	QUALITY ASSURANCE																						
B	NC	0000 mmmm	16220	DIRECTOR QUALITY ASSURANCE	2100 T				MD9			C	+1									+1 →				
B	NC	0000 mmmm	16240	QUALITY ASSURANCE COORDINATOR	2300 T				MD9			C	+1									+1 →				
B	NC	0000 mmmm	16260	RISK MANAGEMENT COORDINATOR	2300 K				MF9			C	+1									+1 →				
B	NC	0000 mmmm	16280	UTILIZATION REVIEW COORDINATOR	2300 K				MF9			C	+1									+1 →				
B	NC	0000 mmmm	43060	PEDIATRICIAN	2100 T	0155			MPB		37100	C	+2									+1 →				
B	NC	0000 mmmm	44060	FAMILY PRACTIONER	2100 T	0108	1618 T		MOB		25300	C	+2									+2 →				
B	NC	0000 mmmm	44300	PHYSICIAN ASST	7540	1099			MNB		34270	C	+2									+2 →				

OPNAV 1000/2 (Rev 12 82)

SN 0107 LF 010 0022

APPENDIX J

SAMPLE NAVAL HOSPITAL BUDGET SUBMISSION

DEPARTMENT OF THE NAVY

[redacted]

7000
[redacted]
24 June 1985

From: [redacted]
To: Commander, Naval Medical Command, Northwest Region, Oakland, CA 94627

Subj: FISCAL YEAR 1986 BUDGET CALL

Ref: (a) NAVMEDCOMNWREG ltr NMCNWREG-11/JLA dtd 9 May 1985
(b) NAVMEDCOM NWREG OAKLAND CA 191905Z JUN 85

Encl: (1) Summary of FY 1986 O&M,N Requirements
(2) NMC-5 Detailed Financial Information for SAG's M9, MA, ME, WH, FD, FF, FG, FN, FQ, FR, FA, FB, FC
(3) NMC-5 (BOS) Base Operations Support
(4) NMC-1 Travel and Transportation Schedule
(5) NMC-15 Schedule of Authorized Positions
(6) NMC-16 Reimbursable Civilian Manpower
(7) NMC-30c Military Personnel
(8) NMC-7 O&M,N Investment Equipment

1. In accordance with references (a) and (b), enclosures (1) through (8) are submitted.

2. Point of contact at this activity is [redacted] MSC, USNR, AUTOVON [redacted] commercial [redacted]

J. L. Peterson
[redacted]
Acting

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Command: [redacted]
UIC:

Summary of FY 1986 O&MN Requirements

SAGS	M9	MA	ME/YQ	WH	FD	FF	FG	FN	FQ	FR	FA/M1	FB/R1	FC
FY 85 APF	$2083.0	$27.0	$27.0	$77.0	$86.8	$98.7	$36.0	$43.0	$4.0	$39.5	$16.0	$20.0	$79.0
Inflation	$ 9.7	$ .2	$ .2	$ .9	$ .6	$ -	$ .7	$ 7.0	$ .2	$ 3.5	$ .7	$ .9	$ -
Increases	$ 114.6	$ 7.0	$ 4.9	$ 9.8	$ 6.0	$12.0	$ -	$ -	$3.0	$ 7.2	$ -	$ 1.5	$ -
Decreases	-	-	-	-	-	$ .1	-	-	-	$ 2.5	-	-	$ 2.0
FY 86 Requirement	$2207.3	$35.2	$32.1	$87.7	$93.4	$110.6	$36.7	$50.0	$7.2	$47.7	$16.7	$22.4	$77.0

NAVAL MEDICAL COMMAND
OPERATION AND MAINTENANCE, NAVY

Command: [redacted] UIC: [redacted]
Activity Group: M9 Station Hospitals and Medical Clinics
Sub-Activity Group: M9 Station Hospitals and Medical Clinics

I Description of Operations Financed: Provides operating resources for Navy medical commands which include hospitals and medical clinics. These facilities differ from those described in Care in Regional Defense Facilities in that the full range of specialized treatment and training is not available at these activities.

II Financial Summary (Dollars in Thousands)

A. Sub-Activity Breakout

	FY 1984 Actual	FY 1985 Current APF	FY 1986 Budget Request	Change 86/85
Total O&M,N	$1824.6	$2083.0	$2207.3	$124.3

B. Schedule of Increases and Decreases

		FY 1985	FY 1986
1.	FY 1985 Current APF	$2083.0	
2.	Pricing Adjustments		$9.7
	a. General Inflation Rate ($941.6 X 4.3%)	+ $40.5	
	b. Defense Logistic Agency Rate ($530.3 X -5.8%)	- $30.8	
3.	Program Increases		$114.6
	a. Increase in contract for dietician services	+ $ 2.0	
	b. Replacement of minor equipment in FY 86 including two electric hospital beds	+ $ 3.0	
	c. Civilian salary step increases	+ $11.7	
	d. Establish contract for librarian	+ $10.0	
	e. Upgrade of Unit Dose System for Pharmacy	+ $ 2.0	
	f. Additional supplies required to support increase in patient population	+ $47.0	
	g. Replacement of IVAC monitors reaching life expectancy	+ $ 9.5	
	h. Consumables required to support FY 86 Investment equipment	+ $ 6.0	
	i. Funding required to support essential training of staff personnel. FY 86 increase in staff is projected to be 9 staff personnel	+ $21.8	

PRODUCED AT GOVERNMENT EXPENSE

Command: [redacted] UIC: [redacted]
Activity Group: M9 Station Hospitals and Medical Clinics
Sub-Activity Group: M9 Station Hospitals and Medical Clinics

j. Supply support for Boardman, OR Clinic + $ 1.6

4. Program Decreases

None

5. FY 1986 Activity Budget Request $2207.3

III Station Hospitals and Medical Clinics	FY 1984	FY 1985	FY 1986
Average Daily Occupied Beds	18	19	20
Average Daily Admissions	6	7	8
Average Daily Outpatients Visits	313	286	315
Average Daily Births	1	1	2
Average Daily Composite Work Units (CWU)	182	185	215

IV Personnel Summary

A. Military Personnel

	FY 1984	FY 1985	FY 1986 Changes Pending
End Strength	133	139	147
Officer	42	48	53
Enlisted	91	91	94
Workyears	124	129	138
Officer	39	44	49
Enlisted	85	85	89

Military End Strength Changes: Military end strength changes are are required to support increased workload and to properly staff facility. Manpower changes are as reflected on Manpower Authorizations for Officers and Enlisted dated 2 Nov 84 and 7 Jan 85.

B. Civilian Personnel (Direct Fund)

	FY 1984	FY 1985	FY 1986 Changes Pending
End Strength	27.0	27.0	27.0
USDH	27.0	27.0	27.0
Workyears	31.0	25.8	27.0
USDH	31.0	25.8	27.0

Command: [redacted] UIC: [redacted]
Activity Group: M9 Station Hospitals and Medical Clinics
Sub-Activity Group: M9 Station Hospitals and Medical Clinics

V	Outyear Data	FY 1987	FY 1988	FY 1989	FY 1990
	O&MN	$2275.4	$2346.5	$2420.6	$2497.9

(Outyear data is inflated by 4.3% per year except for civilian salaries)

Military End Strength	153	153	210	252
Officer	53	53	54	54
Enlisted	100	100	156	198
Civilian End Strength	27	27	27	27
USDH	27	27	27	27

REPRODUCED AT GOVERNMENT EXPENSE

APPENDIX K SAMPLE GEOCOM BUDGET CALL

DEPARTMENT OF THE NAVY
NAVAL MEDICAL COMMAND NORTHWEST REGION
OAKLAND CALIFORNIA 94627-5025

IN REPLY REFER TO
7000
11/JLA
09 MAY 1985

From: Commander, Naval Medical Command, Northwest Region
To: Commanding Officer, [redacted]

Subj: FY 1986 BUDGET CALL

Ref: (a) OPNAVINST 1000.6
(b) COMNAVMEDCOM ltr 5300/CIV; Ser 443/501111401 of 4 Feb 1985

Encl: (1) Instruction for submission of FY 1986 Budget Call
(2) SAG/SFC/EE Submission Format
(3) Manpower Submission Format (Known/Pending Changes)
(4) Manpower Submission Format (Unsubmitted Changes)

1. This command received advance guidance for preparation and submission of FY 1986 budget estimates and requests. This information is forwarded to enable your activity to perform advance planning. At this time the final FY 1985 Annual Planning Figures are not available.

2. The budget call is very similar to the FY 1985 submission and consist of program groups identified by Sub-Activity Groups. The relationship between performance and resources is stressed and will be continuously monitored during the budget review process. Clear and precise explanation and justification of changes in program operations must be provided. Enclosure (1) provides detailed guidance for preparation of the FY 1986 budget estimates and request. Enclosure (2) provides the format to summarize the of requirements by Sub-Activity Group, Sub-Functional Category and expense element. Enclosure (3) provides the format to submit manpower changes which have been approved/directed by NAVMEDCOM or manpower changes which have been submitted and are pending approval. Enclosure (4) provides a formate for manpower changes which have not been submitted to higher authority but are included as new/enhanced programs in this budget submit. A "manpower authorizations change request" must be prepared in accordance with references (a) and (b) for each change identified in enclosure (4) of your FY 86 budget call.

4. The points of contact at this command for this submission are LCDR J. L. Ayers, (Code 11, for finance), or LCDR J. T. Menifee, (Code 12 for manpower) at A/V 855-6200.

T. F. LEVANDOWSKI
Acting

APPENDIX L

SAMPLE MEDCOM BUDGET CALL AND
GEOCOM BUDGET SUBMISSION

DEPARTMENT OF THE NAVY
NAVAL MEDICAL COMMAND
WASHINGTON, D.C. 20372

7000
Ser 11/0046
26 MAR 1985

From: Commander, Naval Medical Command

Subj: FISCAL YEAR 1986 BUDGET CALL PACKAGE

Encl: (1) Instructions for submission of FY 1986 Budget Call

1. Enclosure (1) provides detailed guidance for preparation and submission of FY 1986 budget estimates and requests. As final FY 1985 Annual Planning Figures (APFs) are not yet available to us, enclosure (1) is forwarded at this time to permit advance planning. The actual FY 1986 Budget Call will be issued following completion of the NAVCOMPT Mid-Year Review.

2. As with last year, your budget submission will consist of program groups identified by Sub-Activity Groups (SAGs). This is necessary to relate resources to authorized programs within your assigned mission. The relationship between performance and resources is stressed and continuously monitored during the budget review process. Your budget submission must provide clear and precise explanation and justification of changes in program operations related to changed program requirements.

3. Do not include requests for additional civilian authorizations in your budget submission. Known or pending changes will be identified in your submission, along with an explanation for each change (i.e., reductions brought about by contracting out, etc.). The manpower Division (MEDCOM-44) controls changes in civilian authorizations. Modification of salary limitation will follow revisions in civilian authorizations.

4. Point of contact regarding this package is LCDR R. R. AYERS, MEDCOM-11B, Autovon 294-1350 or commercial (202) 653-1350.

J. G. RADCLIFFE
Deputy Commander for
Financial Management
Acting

REPRODUCED AT GOVERNMENT EXPENSE

REPRODUCED AT GOVERNMENT EXPENSE

GENERAL GUIDANCE FOR PREPARATION OF FY 1986 BUDGET SUBMISSION

The FY 1986 Budget Call consists of preparation and exhibit formats for use in preparing budget submission material. The exhibits are:

Exhibit	Description	Page
NMC-5	Detailed Financial Information	2
NMC-5(BOS)	Performance Evaluation And Criteria (Base Operations Support)	77
NMC-1	Travel And Transportation Of Persons (Object Class 21)	99
NMC-15	Schedule Of Authorized Positions	104
NMC-16	Reimbursable Civilian Manpower	106
NMC-30C	Military Personnel	108
NMC-7	O&M,N Investment Equipment	109

The numbering system utilized for the exhibits corresponds to the exhibit numbers prescribed by NAVCOMPT, OSD and OMB budget submission instructions.

Dollars shall be expressed in whole thousands throughout the exhibits.

Narrative statements must be concise, clear and direct. Specific areas requiring additional funding should identify expected performance changes; justifications; and impact statements if not funded. If changes were directed by higher authority in FY 1986 over FY 1985, identify the directives requiring the changes.

Consolidate requirements for your geographic command and all subordinate commands in a single budget submission.

General definitions:

FY 19PY - Prior fiscal year (i.e., FY 1984)
FY 19CY - Current fiscal year (i.e., FY 1985)
FY 19BY - Budget year (i.e., FY 1986)
APF - Annual Planning Figure
AG - Activity Group
SAG - Sub-Activity Group
SFC - Sub-Functional Code
BOS - Base Operations Support
USDH - U.S. Direct Hire
FNDH - Foreign National Direct Hire
FNIH - Foreign National Indirect Hire
E/S - End Strengtn
IC - Investment Code

INSTRUCTIONS FOR PREPARATION OF NMC-5

Purpose: To provide detailed financial information for each sub-activity group within each activity group of the Operation and Maintenance appropriations.

Submission: The NMC-5 exhibit is required for each third echelon command, inclusive of all subordinate commands.

Civilian and military end strengths will be included. Control numbers for military and civilian end strengths can be verified by Manpower Division, MEDCOM 44 (autovon 294-1329) for use in the NMC-5 exhibit.

Instructions:

I Description of Operations Financed. Provided.

II Financial Summary.

A. Sub-Activity Breakout. Provide sub-activity group dollar distribution. (For sub-activity groups currently consolidated under the FY 1985 Other Base Operating Support (OBOS) APF, identify the sub-activity group distribution within that OBOS total. Then identify each appropriate sub-activity group target under "FY 1985 APF". The total sub-activity group distribution for OBOS must equate to the current FY 1985 APF for OBOS.)

B. Schedule of Increases and Decreases.

1. FY 19CY Current APF. Reflect Sub-Activity Group Total for current APF in the FY 19CY column.

2. Pricing Adjustments. Reflect total in FY 19BY column. List each adjustment by category. The following pricing adjustments shall be used for FY 1986:

(a) General Inflation Rate: Use 4.3 percent, except as indicated below.

(b) Defense Logistic Agency (DLA) Rate: Use -5.8 (deflation) percent for DLA supplied materiel.

(c) Industrial Fund Rates: Use 4.7 percent for industrial fund rates.

(d) Civilian Labor: Do not make a pricing adjustment for civilian labor. This adjustment will be established and applied at a later date.

3. Program Increases. Reflect total in FY 19BY column. List each adjustment by category (e.g., Annualization of FY 19CY Increases, One-Time FY 19BY Costs, Transfers, Other Program Growth in FY 19BY). Provide complete explanation and impact statement for all requirements.

4. Program Decreases. Reflect in same manner at Program Increases.

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5. FY 19BY Activity Budget Request. Use FY 19CY Current APF and all plus or minus adjustments in FY 19BY column to arrive at FY 19BY total.

III Performance Criteria and Evaluation. Criteria necessary to justify program properly.

IV Personnel Summary.

A. Military Personnel. Provide officer and enlisted end strength and workyears. Explain end strength changes between FY 19CY and FY 19BY.

3. Civilian Personnel. Provide end strength and workyears for U.S. Direct Hire (USDH), Foreign National Direct Hire (FNDH) and Foreign National Indirect Hire (FNIH). Explain end strength changes between FY 19CY and FY 19BY.

V Outyear Data. Provide FY 19BY+1 through FY 19BY+4 dollars by sub-activity group, military end strength, and civilian end strength. For any significant civilian manpower change, provide reason (i.e., contracting out, etc.). Do not reflect any pricing adjustments (i.e., inflation indices, etc.) in computing out year funding requirements. Include only outyear funding adjustments brought about by planned program changes identified in FY 19BY.

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NAVAL MEDICAL COMMAND
OPERATION & MAINTENANCE, NAVY

Command: _____ UIC: _____

Activity Group: _____
Sub-Activity Group: _____

I Description of Operations Financed.

II Financial Summary (Dollars in Thousands)

A. Sub-Activity Dollar Distribution

	FY 19PY Actual	FY 19CY Current APF	FY 19BY Budget Request	Change BY/CY
Total O&M,N	X	X	X	X

B. Schedule of Increases and Decreases — FY 19CY — FY 19BY

1. FY 19CY Current APF

2. Pricing Adjustments

a. General Inflation Rate (X)
b. DLA Rate (X)
c. Industrial Fund Rate (X)

3. Program Increases

a. Annualization of FY 19CY Increases (X)

b. One-Time FY 19BY Costs (X)

c. Transfers into base (X)

d. Other Program Growth in FY 19BY (X)

REPRODUCED AT GOVERNMENT EXPENSE

REPRODUCED AT GOVERNMENT EXPENSE

Command: _____ UIC: _____

Activity Group: _____
Sub-Activity Group: _____

Schedule of Increases and Decreases	FY 19CY	FY 19BY
4. Program Decreases		
a. Annualization of FY 19CY Decreases	(X)	
b. One-Time FY 19CY Costs	(X)	
c. Transfers out of base	(X)	
d. Other Program Decreases in FY 19BY	(X)	
5. FY 19BY Activity Budget Request		

III Performance Criteria and Evaluation	FY 19PY	FY 19CY	FY 19BY
Composite Work Units, etc.			

IV Personnel Summary

A. Military Personnel

	FY 19PY	FY 19CY	FY 19BY Changes Pending
End Strength	X	X	X
Officer	X	X	X
Enlisted	X	X	X
Workyears	X	X	X
Officer	X	X	X
Enlisted	X	X	X

Explanation of end strength changes between FY 19CY and FY 19BY:

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IV Personnel Summary

B. Civilian Personnel (Direct Fund)

	FY 19PY	FY 19CY	FY 19BY Changes Pending
End Strength	X	X	X
USDH	X	X	X
FNDH	X	X	X
FNIH	X	X	X
Workyears	X	X	X
USDH	X	X	X
FNDH	X	X	X
FNIH	X	X	X

Explanation of end strength changes between FY 19CY and FY 19BY:

V Outyears Data	FY BY+1	FY BY+2	FY BY+3	FY BY+4
O&M,N	$X	$X	$X	$X
(By Sub-Activity Group)	X	X	X	X
Military E/S	X	X	X	X
Officer	X	X	X	X
Enlisted	X	X	X	X
Civilian E/S	X	X	X	X
USDH	X	X	X	X
FNDH	X	X	X	X
FNIH	X	X	X	X

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REPRODUCED AT GOVERNMENT EXPENSE

S A M P L E

NAVAL MEDICAL COMMAND
OPERATION AND MAINTENANCE, NAVY

Command: Naval Medical Command X Region UIC: 65432
Activity Group: M9 Station Hospitals and Medical Clinics
Sub-Activity Group: M9 Station Hospitals and Medical Clinics

I Description of Operations Financed: Provides operating resources for Navy medical commands which include hospitals and medical clinics. These facilities differ from those described in Care in Regional Defense Facilities in that the full range of specialized treatment and training is not available at these activities.

II Financial Summary (Dollars in Thousands)

A. Sub-Activity Breakout

	FY 1984 Actuals	FY 1985 Current APF	FY 1986 Budget Request	Change 86/85
Total O&M,N	19,917	21,044	23,085	2,041

B. Schedule of Increases and Decreases

		FY 1985	FY 1986
1.	FY 1985 Current APF	$21,044	
2.	Pricing Adjustments		+ 365
	a. General Inflation Rate (4.3%) +304		
	b. DLA Inflation Rate (-5.8%) -9		
	c. Industrial Fund Rate (4.7%) +70		
3.	Program Increases		+ 1,821
	a. Annualization of FY 1985 Increases (+58)		
	(1) TRIMIS Consumables +11 (Explanation/impact of requirement)		
	(2) Computer Assisted Tomography Scanners +47 (Explanation/impact of requirement)		
	b. Other Program Growth FY 1986 (+1,763)		
	(1) One Day Pay +33 (Explanation/impact of requirement)		
	(2) CHAMPUS Workload Shift +193 (Explanation/impact of requirement)		
	(3) Automated Clinical System Expansion +514 (Explanation/impact of requirement)		

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	(4) Tri-Service Medical Information System Funding Methodology Change	+129	
	(Explanation/impact of requirement)		
	(5) Equipment Funding Shift	+177	
	(Explanation/impact of requirement)		
	(6) Activity Duty Strength Increase	+ 89	
	(Explanation/impact of requirement)		
	(7) Contract Surgeons	+634	
	(Explanation/impact of requirement)		
4.	Program Decreases		- 145
	a. Annualization of FY 1985 Decreases	(-118)	
	(1) Nurses Military Substitution	- 28	
	(Explanation of savings)		
	(2) Efficiency Reviews	- 15	
	(Explanation of savings)		
	(3) Contract Out Savings	- 75	
	(Explanation of savings)		
	b. Other Program Decreases in FY 1986	(- 27)	
	(1) Nurse Military Substitution - Third Increment	- 27	
	(Explanation of decrease)		
5.	FY 1986 Activity Budget Request		23,085

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Command: Naval Medical Command X Region UIC: 65432
Activity Group: M9 Station Hospitals and Medical Clinics
Sub-Activity Group: M9 Station Hospitals and Medical Clinics

III Performance Criteria and Evaluation

The medical workload is measured by use of the composite work unit. The weighted formula used to compute the composite work unit total is illustrated below.

	Workload	Conversion Factor	Composite Work Unit
Average Daily Occupied Beds	341.2	X 1	341.2
Average Daily Admissions	62.5	X10	625.0
Average Daily Outpatients Visits	3,355.3	X.3	1,006.6
Average Daily Births	8.6	X10	86.0
FY 1986 Composite Work Unit Total			2,058.8

Station Hospitals and Medical Clinics	FY 1984	FY 1985	FY 1986
Average Daily Occupied Beds	294.7	312.6	341.2
Average Daily Admissions	53.6	57.5	62.5
Average Daily Outpatients Visits	123.4	3,256.3	3,355.3
Average Daily Births	7.7	8.3	8.6
Avg Daily Composite Work Units (CWU)	1,846.8	1,948.0	2,059.8

IV Personnel Summary

A. Military Personnel

	FY 1984	FY 1985	FY 1985 Changes Pending
End Strength	1,535	1,752	1,800
Officer	470	520	553
Enlisted	1,065	1,232	1,247
Workyears	1,475	1,643	1,776
Officer	449	495	536
Enlisted	1,027	1,148	1,240

Military End Strength Changes: +2 officer end strengths added as the third increment of the substitution of military nurses for civilian nurses. +31 officers and +15 enlisted end strengths added to improve wartime medical capability. During peacetime, this manpower provides means of increasing in-house workload and reducing CHAMPUS workload.

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REPRODUCED AT GOVERNMENT EXPENSE

S A M P L E

Command: Naval Medical Command X Region UIC: 65432
Activity Group: M9 Station Hospitals and Medical Clinics
Sub-Activity Group: M9 Station Hospitals and Medical Clinics

B. Civilian Personnel (Direct Fund)

	FY 1984	FY 1985	FY 1986 Changes Pending
End Strength	436	434	445
USDH	371	368	383
FNDH	24	24	22
FNIH	41	42	40
Workyears	442	427	434
USDH	378	363	372
FNDH	24	24	23
FNIH	39	40	39

Civilian End Strength Changes: +8 end strengths added to provide licensed pharmacists at major branch clinics. +5 end strengths added for phased expansion of TRIMIS program at Naval Hospital A. -2 end strengths removed as part of the third increment of the program to replace civilian nurses with military nurses both for mobilization improvement and to alleviate turnover problems associated with civilian nurses.

V Outyear Data

	FY 1987	FY 1988	FY 1989	FY 1990
O&MN	23,085	24,110	24,110	24,110
Military End Strength	2,015	2,120	2,139	2,152
Officer	624	658	660	664
Enlisted	1,391	1,462	1,479	1,488
Civilian End Strength	440	432	429	429
USDH	379	370	368	368
FNDH	22	22	22	22
FNIH	39	39	39	39

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REPRODUCED AT GOVERNMENT EXPENSE

NAVAL MEDICAL COMMAND
OPERATION AND MAINTENANCE, NAVY

Command: _____ UIC: _____
Activity Group: F3 Base Operations
Sub-Activity Group: FF Administration

I Description of Operations Financed: Includes the costs for shore based support functions of administration and command, management engineering and industrial management; comptroller services; civilian manpower management; military personnel management; administrative office services; word processing; dependent schools, personnel planning functions, miscellaneous services and functions; support groups/units assigned to those functions. Also provides for shore base activation. ADP support expenses are included in Automatic Data Processing Services (FQ).

II Financial Summary (Dollars in Thousands)

A. Sub-Activity Breakout

	FY 1984 Actuals	FY 1985 Current APF	FY 1986 Budget Request	Change 86/85
Total O&M,N				

3. Schedule of Increases and Decreases — FY 1985 — FY 1986

1. FY 1985 Current APF
2. Pricing Adjustments
3. Program Increases
4. Program Decreases
5. FY 1986 Activity Budget Request

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